BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **MICHAEL JOSEPH MCANDREWS** **a.k.a. MICHAEL J. MCANDREWS** **510 Clapboard Tree** **Westwood, MA 02090** **Registered Nurse License No. 589023** RESPONDENT	Case No. 2013-367 **DEFAULT DECISION AND ORDER** [Gov. Code, §11520]

FINDINGS OF FACT

1. On or about November 5, 2012, Complainant Louise R. Bailey, M.Ed.,RN, in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs, filed Accusation No. 2013-367 against Michael Joseph McAndrews, aka Michael J. McAndrews (Respondent) before the Board of Registered Nursing. (Accusation attached as Exhibit A.)

2. On or about October 11, 2001, the Board of Registered Nursing (Board) issued Registered Nurse License No. 589023 to Respondent. The Registered Nurse License expired on June 30, 2009 and has not been renewed.

3. On or about November 5, 2012, Respondent was served by Certified and First Class Mail copies of the Accusation No. 2013-367, Statement to Respondent, Notice of Defense, Request for Discovery, and Government Code sections 11507.5, 11507.6, and 11507.7 to Respondent's address of record which, pursuant to Business and Professions Code section 136 and/Title 16, California Code of Regulation, section 1409.1, is required to be reported and maintained with the Board, which was and is:

510 Clapboard Tree

Westwood, MA 02090.

4. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c) and/or Business & Professions Code section 124.

5. On or about November 26, 2012, the First Class Mail documents were returned by US Postal Service marked "Not Deliverable As Addressed, Unable to Forward" and on or about December 4, 2012, the Certified mail documents were returned marked "Unclaimed." The address on the documents was the same as the address on file with the Board. Respondent failed to maintain an updated address with the Board and the Board has made attempts to serve the Respondent at the address on file. Respondent has not made himself available for service and therefore, has not availed himself of his right to file a notice of defense and appear at hearing.

6. Business and Professions Code section 2764 states:

The lapsing or suspension of a license by operation of law or by order or decision of the board or a court of law, or the voluntary surrender of a license by a licentiate shall not deprive the board of jurisdiction to proceed with an investigation of or action or disciplinary proceeding against such license, or to render a decision suspending or revoking such license.

7. Government Code section 11506 states, in pertinent part:

(c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing.

8. Respondent failed to file a Notice of Defense within 15 days after service of the Accusation upon him, and therefore waived his right to a hearing on the merits of Accusation No. 2013-367.

9. California Government Code section 11520 states, in pertinent part:

(a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent.

10. Pursuant to its authority under Government Code section 11520, the Board after having reviewed the proof of service dated November 5, 2012, signed by Brent Farrand, and the returned envelopes finds Respondent is in default. The Board will take action without further hearing and, based on Accusation No. 2013-367 and the documents contained in Default Decision Investigatory Evidence Packet in this matter which includes:

Exhibit 1: Pleadings offered for jurisdictional purposes; Accusation No. 2013-367, Statement to Respondent, Notice of Defense (two blank copies), Request for Discovery and Discovery Statutes (Government Code sections 11507.5, 11507.6 and 11507.7), proof of service; and if applicable, mail receipt or copy of returned mail envelopes;

Exhibit 2: License History Certification for Michael Joseph McAndrews, aka Michael J. McAndrews, Registered Nurse License No. 589023;

Exhibit 3: Affidavit of Kami Pratab;

Exhibit 4: Out of State Discipline (Texas and Massachusetts Boards of Nursing);

Exhibit 5: Declaration of costs by Office of the Attorney General for prosecution of Case No. 2013-367.

The Board finds that the charges and allegations in Accusation No. 2013-367 are separately and severally true and correct by clear and convincing evidence.

11. Taking official notice of Certification of Board Costs and the Declaration of Costs by the Office of the Attorney General contained in the Default Decision Investigatory Evidence Packet, pursuant to the Business and Professions Code section 125.3, it is hereby determined that the reasonable costs for Investigation and Enforcement in connection with the Accusation are $505.00 as of January 8, 2013.

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DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent Michael Joseph McAndrews, aka Michael J. McAndrews has subjected his following license(s) to discipline:

a. Registered Nurse License No. 589023

2. The agency has jurisdiction to adjudicate this case by default.

3. The Board of Registered Nursing is authorized to revoke Respondent's license(s) based upon the following violations alleged in the Accusation, which are supported by the evidence contained in the Default Decision Investigatory Evidence Packet in this case.

a. Violation of Business and Professions Code section 2761(a)(4) - Disciplinary action by another State Board of Nursing.

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ORDER

IT IS SO ORDERED that Registered Nurse License No. 589023, heretofore issued to Respondent Michael Joseph McAndrews, aka Michael J. McAndrews, is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on MAY 02, 2013.

It is so ORDERED APRIL 02, 2013

Board of Registered Nursing
Department of Consumer Affairs
State of California

Attachment:

Exhibit A: Accusation No. 2013-367

Exhibit A

Accusation No. 2013-367

KAMALA D. HARRIS
Attorney General of California
ALFREDO TERRAZAS
Senior Assistant Attorney General
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Sacramento, CA 94244-2550
Telephone: (916) 445-7384
Facsimile: (916) 327-8643
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **MICHAEL JOSEPH McANDREWS, AKA MICHAEL J. McANDREWS** 510 Clapboard Tree Westwood, Massachusetts 02090 **Registered Nurse License No. 589023** Respondent.	Case No. 2013 - 367 **ACCUSATION**

Louise R. Bailey, M.Ed., R.N. ("Complainant") alleges:

PARTIES

1. Complainant brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

Registered Nurse License

2. On or about October 11, 2001, the Board issued Registered Nurse License Number 589023 to Michael Joseph McAndrews, also known as Michael J. McAndrews ("Respondent"). The registered nurse license expired on June 30, 2009.

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JURISDICTION

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with Code section 2750) of the Nursing Practice Act.

4. Code section 118, subdivision (b), provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued, or reinstated.

5. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

6. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action.

COST RECOVERY

7. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

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CAUSE FOR DISCIPLINE

(Out-of-State Discipline)

8. Respondent is subject to discipline pursuant to Code section 2761, subdivision (a)(4), on the grounds of unprofessional conduct, as follows:

a. Effective October 26, 2011, the Texas Board of Nursing, in a disciplinary action entitled *In the Matter of Registered Nurse License Number 613739 issued toMichael J. McAndrews*, issued an *Order of the Board* (attached hereto as Exhibit A and incorporated herein by reference), accepting the voluntary surrender of Respondent's license to practice professional nursing in the State of Texas. The disciplinary action was based on the *Final Decision and Order* issued by the Board of Registration in Nursing, Commonwealth of Massachusetts, as described in subparagraph b, below.

b. Effective December 23, 2010, the Board of Registration in Nursing, Commonwealth of Massachusetts, in a disciplinary action entitled *In the Matter of Michael J. McAndrews RN License No. 239918 License expired 5/21/2010,* Docket No. RN-06-177, issued a *Final Decision and Order* (attached hereto as Exhibit B and incorporated herein by reference) indefinitely suspending Respondent's right to renew his license to practice as a registered nurse in Massachusetts. The basis of such action is that between on or about January 10, 2006, and January 11, 2006, Respondent failed to comply and comport with accepted standards of nursing practice by exhibiting inappropriate and unprofessional conduct. Such conduct includes, but not is not limited to: Respondent's interference with care provided to "Patient A" by the nurse primarily responsible for Patient A; diagnosing Patient A and then discussing that diagnosis with the patient and his colleagues; ordering the primary nurse to change Patient A's prescribed medication; loudly proclaiming that Patient A, an alert and aware telemetry patient, was going into "sudden death" while he paced a corridor adjacent to her hospital room; and, asking Patient A whether she was seeing a "white light" to assess her "neuro/spiritual" condition.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 589023, issued to Michael Joseph McAndrews, also known as Michael J. McAndrews;

2. Ordering Michael Joseph McAndrews, also known as Michael J. McAndrews, to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: November 5, 2012

for LOUISE R. BAILEY, M.ED., R.N.
Executive Officer
Board of Registered Nursing
State of California
Complainant

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EXHIBIT A

Order

In the Matter of Registered Nurse License Number 613739 issued toMichael J. McAndrews

State of Texas Board of Nursing

BEFORE THE TEXAS BOARD OF NURSING

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In the Matter of Registered Nurse §
License Number 613739 §
issued to MICHAEL J. MCANDREWS §

ORDER OF THE BOARD

On this day, the Texas Board of Nursing, hereinafter referred to as the Board, accepted the voluntary surrender of Registered Nurse License Number 613739, issued to MICHAEL J. MCANDREWS, hereinafter referred to as Respondent. This action was taken in accordance with Section 301.453(c), Texas Occupations Code.

Respondent waived representation by counsel, informal proceedings, notice and hearing.

The Board makes the following Findings of Fact and Conclusions of Law.

FINDINGS OF FACT

1. Respondent holds a license to practice professional nursing in the State of Texas which is in delinquent status.

2. Respondent waived representation by counsel, informal proceedings, notice and hearing.

3. Respondent received an Associate Degree in Nursing from Central Texas College, Killeen, Texas, on December 1, 1994. Respondent was licensed to practice professional nursing in the State of Texas on February 14, 1995.

4. Respondent's nursing employment history is unknown.

5. Formal Charges were filed on September 27, 2011. A copy of the Formal Charges is attached and incorporated by reference as part of this Order.

6. Formal Charges were mailed to Respondent on September 27, 2011.

8. On October 19, 2011, the Board received a statement from Respondent voluntarily surrendering the right to practice nursing in Texas. A copy of Respondent's statement, dated October 19, 2011, is attached and incorporated herein by reference as part of this Order.

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555, the Board has jurisdiction over this matter.

2. Notice was served in accordance with law.

3. The evidence received is sufficient to prove a violation of Section 301.452(b)(8), Texas Occupations Code.

4. Under Section 301.453(c), Texas Occupations Code, the Board has the authority to accept the voluntary surrender of a license.

5. Under Section 301.453(d), Texas Occupations Code, the Board may impose conditions for reinstatement of licensure.

6. Any subsequent reinstatement of this license will be controlled by Section 301.452 (b), Texas Occupations Code, and 22 TAC§§213.26-.29, and any amendments thereof in effect at the time of the reinstatement.

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ORDER

NOW, THEREFORE, IT IS ORDERED that the voluntary surrender of Registered Nurse License Number 613739, heretofore issued to MICHAEL J. MCANDREWS, to practice professional nursing in the State of Texas, is accepted by the Executive Director on behalf of the Texas Board of Nursing. In connection with this acceptance, the Board imposes the following conditions:

1. RESPONDENT SHALL NOT practice professional nursing, use the title of registered nurse or the abbreviation "RN" or wear any insignia identifying himself as a registered nurse or use any designation which, directly or indirectly, would lead any person to believe that RESPONDENT is a registered nurse during the period in which the license is surrendered.

2. RESPONDENT SHALL NOT petition for reinstatement of licensure until: one (1) year has elapsed from the date of this Order.

3. Upon petitioning for reinstatement, RESPONDENT SHALL satisfy all then existing requirements for relicensure.

IT IS FURTHER AGREED and ORDERED that this Order SHALL be applicable to Respondent's nurse licensure compact privileges, if any, to practice professional nursing in the State of Texas.

Effective this **26th** day of **October**, **2011**.

TEXAS BOARD OF NURSING

By: Katherine A. Thomas

Katherine A. Thomas, MN, RN
Executive Director on behalf
of said Board

I certify this to be a true copy of the records on file with the Texas Board of Nursing.
Date: 12-8-11
Signed: Barbara Darling

In the Matter of Permanent License	§	**BEFORE THE TEXAS**
Number 613739, Issued to	§	
MICHAEL J. MCANDREWS, Respondent	§	**BOARD OF NURSING**

FORMAL CHARGES

This is a disciplinary proceeding under Section 301.452(b), Texas Occupations Code. Respondent, MICHAEL J. MCANDREWS, is a Registered Nurse holding license number 613739, which is in delinquent status at the time of this pleading.

Written notice of the facts and conduct alleged to warrant adverse licensure action was sent to Respondent at Respondent's address of record and Respondent was given opportunity to show compliance with all requirements of the law for retention of the license prior to commencement of this proceeding.

CHARGE I.

On or about December 13, 2010, Respondent's license to practice professional nursing in Massachusetts was suspended by the Board of Registration in Nursing. A copy of the Final Decision and Order dated December 13, 2010, is attached and incorporated by reference as part of this Order.

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(8), Texas Occupations Code.

NOTICE IS GIVEN that staff will present evidence in support of the recommended disposition of up to revocation of Respondent's license to practice nursing in the State of Texas pursuant to the Nursing Practice Act, Chapter 301, Texas Occupations Code and the Board's rules, 22 Tex. Admin. Code §§ 213.27 - 213.33. and TEX. OCC. CODE Ch. 53. Additionally, staff will seek to impose on Respondent the administrative costs of the proceeding pursuant to Section 301.461, Texas Occupations Code. The cost of proceedings shall include, but is not limited to, the cost paid by the Board to the State Office of Administrative Hearings and the Office of the Attorney General or other Board counsel for legal and investigative services, the cost of a court reporter and witnesses, reproduction of records, Board staff time, travel, and expenses. These shall be in an amount of at least one thousand two hundred dollars ($1200.00).

NOTICE IS GIVEN that all statutes and rules cited in these Charges are incorporated as part of this pleading and can be found at the Board's website, www.bon.state.tx.us.

NOTICE IS GIVEN that, based on the Formal Charges, the Board will rely on the Disciplinary Matrix, which can be found at www.bon.state.tx.us/disciplinaryaction/discp-matrix.html.

NOTICE IS ALSO GIVEN that Respondent's past disciplinary history, as set out below and described in the Orders which is/are attached and incorporated by reference as part of these charges, will be offered in support of the disposition recommended by staff: Agreed Order dated December 13, 2010, issued by the Commonwealth of Massachusetts, Executive Office of Health and Human Services, Department of Public Health, Division of Health Professions Licensure, Board of Registration in Nursing, Boston, Massachusetts.

Filed this 27th day of September, 2011.

TEXAS BOARD OF NURSING

James W. Johnston, General Counsel
Board Certified - Administrative Law
Texas Board of Legal Specialization
State Bar No. 10838300
Jena Abel, Assistant General Counsel
State Bar No. 24036103
Lance Robert Brenton, Assistant General Counsel
State Bar No. 24066924
Robert Kyle Hensley, Assistant General Counsel
State Bar No. 50511847
Nikki Hopkins, Assistant General Counsel
State Bar No. 24052269
John F. Legris, Assistant General Counsel
State Bar No. 00785533
TEXAS BOARD OF NURSING
333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701
P: (512) 305-6824
F: (512) 305-8101 or (512)305-7401

Attachments: Order of the Board dated December 13, 2010, issued by the Commonwealth of Massachusetts, Executive Office of Health and Human Services, Department of Public Health, Division of Health Professions Licensure, Board of Registration in Nursing, Boston, Massachusetts.

D/2010.12.28

EXHIBIT B

Final Decision and Order
Board of Registration in Nursing
In the Matter of Michael J. McAndrews RN License No. 23991
Docket No. RN-06-177
Commonwealth of Massachusetts

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK COUNTY

BOARD OF REGISTRATION
IN NURSING

In the Matter of Michael J. McAndrews RN License No. 239918 License expired 5/21/2010	)	Docket No. RN-06-177

FINAL DECISION AND ORDER[1]

I. PROCEDURAL BACKGROUND

On June 23, 2008, the Board of Registration in Nursing ("Board") issued an Amended Order to Show Cause ("Amended Order") to Respondent Michael J. McAndrews ("Respondent"), a nurse licensed by the Board to practice nursing in Massachusetts.[2] The Amended Order directed Respondent to appear and show cause why the Board should not suspend, revoke, or otherwise take action against his license to practice nursing pursuant to 244

[1] Pursuant to 801 CMR 1.01 (11)(c), the Board issued a tentative decision in the first instance.

[2] An Order to Show Cause and Answer were originally filed on February 25, 2008 and March 4, 2008 respectively. A Status Conference scheduled for April 7, 2008 was continued to May 21, 2008 due to Prosecuting Counsel's illness. On May 14, 2008, Respondent filed a Motion for Particulars, which was opposed by Prosecuting Counsel on May 21, 2008. The motion became moot as it was established at the May 21, 2008 Status Conference that Prosecuting Counsel would file an Amended Order to Show Cause.

Respondent was initially represented by Sanford Kowal, Esq. At the hearing on February 23, 2009, Respondent and Attorney Kowal quarreled over whether to cross-examine Prosecuting Counsel's last witness of the day. During a recess, Respondent and his attorney were unable to resolve their differences and came to blows. Before going back on the record, Respondent stated that he intended to represent himself for the remainder of the proceeding and had no questions for the witness. Respondent was extremely upset and left the building. The hearing was reconvened and Attorney Kowal stated that he continued to represent Respondent and had no questions for the witness. On the next day of hearing, February 25, 2008, Attorney Kowal withdrew his appearance at Respondent's request. Respondent has appeared *pro se* since February 25, 2009.

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CMR 9.03 and G.L. C. 112, § 61, based upon the allegations contained in the Amended Order. Said allegations pertained to Respondent's conduct in asking a Brockton Hospital cardiac patient to whom he was not assigned whether she had seen a "white light"; interfering with the care of said patient, including insisting that the nurse assigned to care for the patient discontinue a medication ordered by the patient's physician; and failing to maintain a therapeutic environment for the patient by pacing through the hospital corridor and loudly proclaiming that the patient was experiencing "sudden death". Additionally, the Amended Order charged Respondent with filing with the Board a letter he had written to Brockton Hospital administrators containing inappropriate and offensive language used to describe a nursing colleague.

Respondent filed his Answer to the First Amended Order on June 30, 2008, in essence denying the claims against him. Respondent also filed a request for hearing and moved to dismiss the case against him.

On July 7, 2008, the Board declared that it was unable to rule on the motion to dismiss as the motion was incomprehensible to the Board, relying on documents and events that were foreign to the Board.

On July 23, 2008, Respondent filed a Motion for Particulars with regard to the First Amended Order. Prosecuting filed an opposition on July 30, 2008, and Respondent's motion was denied on August 4, 2008.

A Pre-Hearing Conference was convened on October 15, 2008. Prosecuting Counsel submitted his Pre-Hearing Memorandum and proposed exhibits, as required by the Notice of Pre-Hearing Conference issued by the Board. Respondent failed to submit a Pre-Hearing Memorandum and proposed exhibits. He was allowed until November 10, 2008 to submit the documents. On November 12, 2008, Respondent filed his Pre-Hearing Memorandum and exhibits. At the Pre-Hearing Conference, Respondent moved to continue the first scheduled day of hearing, November 5, 2008,[3] because of a scheduling conflict and medical records related to the case that he had requested and not

[3] Pursuant to the May 21, 2008 Status Conference and Scheduling Order issued by the Board, hearing dates were set for November 5 and 17, 2008 and December 8 and 15, 2008.

yet received from Brockton Hospital. The first day of hearing was continued to December 8, 2008 and additional hearing dates were scheduled for January 14 and 21, 2009.

Also on October 15, 2008, Respondent filed a motion to transfer the proceedings before the Board to the Division of Administrative Law Appeals ("DALA"). The Board denied the motion in a ruling issued on November 17, 2008.

On November 3, 2008, Respondent filed motions to file interrogatories and to enforce a subpoena issued to Brockton Hospital. Prosecuting Counsel filed an opposition to the motions on November 5, 2008. The motions were denied on November 7, 2008.

On November 25, 2008, Brockton Hospital moved to modify a *subpoena duces tecum* served by Respondent on October 21, 2008. On December 3, 2008, the Board issued a ruling allowing the motion in part and denying the motion in part. On December 9, 2008, Respondent filed a motion asking the Board to reconsider its ruling. Respondent's motion was denied on December 22, 2008..

On December 7, 2008, Respondent moved to continue the hearing, scheduled to begin on December 8, 2008, because of Attorney Kowal's hospitalization. The Board granted a continuance and re-scheduled the first day of hearing for January 21, 2009.

On December 5, 2008, Prosecuting Counsel filed an Opposition to Testimony of Respondent's Witnesses. For health reasons, Respondent was granted an extension of time to file an opposition. An opposition was filed on January 2, 2009. Prosecuting Counsel's Opposition to Testimony of Respondent's Witnesses was allowed in part and denied in part.

On January 6, 2009, Respondent moved to amend his Pre-Hearing Memorandum. Prosecuting Counsel was allowed an extension of time to oppose the motion. He filed his Opposition on January 14, 2009. On January 16, 2009, the Board allowed Respondent's motion.

A true and correct copy. Cat.

Also on January 6, 2009 Respondent filed various motions to dismiss and a motion for a protective order. Following an extension of time, Prosecuting Counsel filed his opposition to said motions on January 14, 2009. The Board denied each of Respondent's motions.

On January 13, 2009, Respondent filed a Motion in Limine seeking to prohibit the testimony of Prosecuting Counsel's expert witness relative to certain issues. Prosecuting Counsel opposed the motion on January 14, 2009. On January 16, 2009, the Board issued a ruling denying the motion.

The Hearing commenced on January 21, 2009 and continued on February 4, 23, and 25, 2009. Additional hearing dates were scheduled for April 25 and 27, 2009 and May 27, 2009.

On April 15, 2009, Respondent, now representing himself, filed a motion to dismiss. Prosecuting Counsel opposed the motion and a ruling issued by the Board on April 15, 2009 denied the motion. (All communications were via electronic mail ["e-mail"]).

On April 17, 21, and 22, Respondent filed additional motions to dismiss the proceedings. Prosecuting Counsel opposed the motions. Each of the motions to dismiss were denied by the Board on April 22, 2009. (All communications were via e-mail).

On April 27, 2009, Respondent filed a Motion to Strike and Motion for More Definite Statement. Prosecuting Counsel filed an opposition, and the Board denied the motions on April 27, 2009. (All communications were via e-mail).

On May 8, 2009, the Board issued a Notice of Reconvened Hearing for May 27, 2009. The purpose of the May 27, 2009 hearing was to allow Respondent an opportunity to present the testimony of three (3) witnesses. (Respondent testified in his own defense on April 27, 2009). On May 4, 2009, Respondent moved to continue the May 27, 2009 hearing. Between May 5, 2009 and May 7, 2009, Respondent filed three (3) motions to dismiss the proceedings. On May 8, 2009, the Board issued a ruling denying Respondent's

motion to continue the May 27, 2009 hearing date and each of Respondent's motions to dismiss.

On May 11, 2009, Respondent filed another motion to continue the hearing set for May 27, 2009. The motion was denied on May 15, 2009.

Respondent failed to appear at the May 27, 2009 hearing.[4] Prosecuting Counsel made an oral motion to default Respondent, which was denied. Prosecuting Counsel waived his closing statement. Also on May 27, 2009, the Board issued a Procedural Order declaring the evidentiary record closed and directing that Briefs be filed by August 31, 2009.

On May 28, 2009, Prosecuting Counsel filed a motion for the entry of default and for a Final Decision and Order by Default. Alternatively, Prosecuting Counsel moved that Respondent be denied additional time to present evidence. On June 3 and 4, 2009, Respondent filed motions for default and dismissal. On June 15, 2009, the Board denied each of these motions filed by Prosecuting Counsel and Respondent.[5]

Briefs were filed by Prosecuting Counsel on August 30, 2009 and by Respondent on September 3, 2009.

On July 20, 2010, Respondent moved to recuse the Administrative Hearings Counsel for these proceedings. The motion was denied.

As noted, a formal adjudicatory hearing ("hearing") was held before Administrative Hearings Counsel Vivian Bendix, Esq., in accordance with G.L. c. 30A and the Standard Adjudicatory Rules of Practice and Procedure, 801 CMR 1.01, *et seq.* Hearing dates were January 21, 2009, February 4, 2009, February 23, 2009, February 25, 2009, April 25, 2009, April 27, 2009, and May 27, 2009. Prosecuting Counsel was Paul C. Moore, Esq. Respondent was

[4] Following the close of the hearing on May 27, 2009, it came to the attention of Prosecuting Counsel and Administrative Hearings Counsel that Respondent had filed several motions in Superior Court, including a motion to enjoin the proceedings before the Board. The Court issued a ruling denying the motions, noting that the Court was not able to comprehend the grounds for the motions or the relief sought. Also, the Court noted that the motions were not timely filed.

[5] With regard to Prosecuting Counsel's request that Respondent be denied additional time to present evidence, the Board noted that the record had already been closed in accordance with the May 27, 2009 Procedural Order.

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present and represented by Sanford Kowal on the first three days of hearing. Respondent appeared *pro se* on February 25, 2009, April 25, 2009, and April 27, 2009. Respondent failed to appear on May 27, 2009.

In accordance with 801 CMR 1.01 (11)(c), the Board issued a Tentative Decision on October 22, 2010. On October 29, 2010, Respondent filed a letter in response to the Tentative Decision. Respondent had no objections to the Tentative Decision. Rather, he stated that he was currently under treatment for "... my behaviors, including the ones that you have outlined in the Tentative Decision for which I deeply apologize and acknowledge to the Board..." Referencing his treatment and a disabling medical diagnosis, Respondent stated that he has "permanently withdrawn from the profession of Registered Nursing for an indefinite time." Respondent requested that his treatment and "...permanent medical withdrawal from the Nursing Profession in all states *suffice as a resolve for the disciplinary action sought as I continue ongoing treatment...*"

On November 17, 2010, Prosecuting Counsel filed a response to the Tentative Decision, stating that in lieu of filing objections, he was identifying a few typographical errors. (Those errors have been corrected in this Final Decision and Order). Additionally, Prosecuting Counsel noted that to the extent that Respondent's response to the Tentative Decision may be interpreted as seeking a nondisciplinary outcome of this matter, he (Prosecuting Counsel) opposed such a request. Prosecuting Counsel observed that during the long pendency of this matter, the Board made repeated offers of settlement and Respondent was given multiple opportunities to resolve the matter by taking the type of steps that he has now taken.

The following witnesses testified at the formal adjudicatory hearing:[6]

For the Prosecution:
Eileen Brady, R.N.

[6] Witnesses were sequestered throughout the proceedings.
In citations to testimony throughout this Final Decision and Order, witnesses are referenced by their surnames. Respondent Michael J. McAndrews is referenced as Respondent.

A true certified copy -cm3

Corrine Bryant, R.N.

Robert Covett, D.O.

Bruce Kriegel, M.D.

Rosemarie Marks, R.N.

Christine Sconyers, R.N.

Colleen Snydeman, R.N. M.S.N., expert

Debra Sturge, R.N.

Kimberly Walsh, R.N.

For Respondent:

Respondent

II. Exhibits[7]

Exhibit 1	June 23, 2008 Cover Letter and First Amended Order to Show Cause, dated June 23, 2008
Exhibit 2	Answer to First Amended Order to Show Cause and Request for A Hearing, filed June 30, 2008[8]
Exhibit 3	Statement of Eileen Brady, R.N. ("Brady"), January 10, 2008
Exhibit 4	Brady's Nursing Progress Notes for Patient A, January 11, 2006
Exhibit 5	Telemetry Flow Sheet for Patient A, undated
Exhibit 6	Patient Care Referral for Patient A, January 11, 2006[9]
Exhibit 7	Telemetry Unit Physician's Order Form for Patient A, January 10-11, 2006[10]

[7] At the Hearing, exhibits were entered into evidence as Exhibits 1-11 and 13-32. By error of omission, the record does not contain an Exhibit 12. Exhibits 8 and 14 are identical.

[8] The "Notice of Service" included with the Answer to the First Amended Order to Show Cause erroneously states that the document was served on February 26, 2008. The accompanying envelope establishes that it was received by Administrative Hearings Counsel on June 30, 2008. The Certificate of Service for the Request for A Hearing, which was filed simultaneously, states June 26, 2008 as the date of service.

[9] The date on the Patient Care Referral Form is January 10, 2006. The evidence established that the actual date was January 11, 2006.

[10] The Physician's Order Form is date stamped January 10, 2006. The document was initiated on January 10, 2006 and continued on January 11, 2006. It contains orders given on both dates.

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Exhibit 8	Emergency Department Physician's Order Form, January 10, 2006
Exhibit 9	Medication Administration Record for Patient A, January 10-12, 2006
Exhibit 10	Telemetry Unit Vital Signs Flow Sheet for Patient A, undated
Exhibit 11	Telemetry Unit Flow Sheet/Nursing Assessment for Patient A, January 10, 2006
Exhibit 13	Excerpt from performance evaluation for Respondent, dated September 8, 2005
Exhibit 14	Emergency Department Physician's Order Form, January 10, 2006
Exhibit 15	Critical Care Flow Sheet for Patient A, January 12, 2006
Exhibit 16	Telemetry Unit Nursing Progress Note for Patient A with EKG tracings, January 10-11, 2006
Exhibit 17	Complaint and attachments filed with Board by Kimberly Walsh, March 14, 2006
Exhibit 18	Critical Care Progress Notes for Patient A, January 11, 2006
Exhibit 19	Report of Consultation of Bruce Kriegel, MD re: Patient A, January 10, 2006
Exhibit 20	Progress Note of Andrew Kriegel, MD and Case Management Note for Patient A, January 15, 2006
Exhibit 21	Progress Note of Bruce Kriegel, MD for Patient A, January 16, 2006
Exhibit 22	EKG Tracing and Progress Note of Bruce Kriegel, MD for Patient A, January 17-18, 2006
Exhibit 23	Physician's Order Form for Patient A, January 17, 2006
Exhibit 24	Physician's Order Form for Patient A, January 18-19, 2006
Exhibit 25	Physician's Progress Note for Patient A, January 15, 2006
Exhibit 26	Curriculum Vitae of Colleen Snydeman, RN, MSN, undated
Exhibit 27	Respondent's Narrative of Events re: Patient A on January

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11, 2006, undated[11]

Exhibit 28 Article: *A Model of Recovering Medical Errors in the Care Unit*, Heart and Lung, Vol. 37, No. 3

Exhibit 29 Diagram of Telemetry Unit, produced by Christine Sconyers, R.N. at April 29, 2009 hearing

Exhibit 30 Telemetry Unit Vital Signs Flow Sheet for Patient A, January 10; 2006

Exhibit 31 Resume of Respondent, undated

Exhibit 32 Document prepared by Respondent entitled *A Closer Look at January 11, 2006*, undated

Exhibits for Identification[12]

Exhibit 1 Diagram of Telemetry Unit produced by Eileen Brady, R.N. at January 21, 2009 hearing

Exhibit 6 Decision of Kathleen Anderson, Review Examiner, Massachusetts Division of Unemployment Assistance, Docket Number 437990, undated[13]

[11] Exhibit 27 is a single page that is part of a larger document submitted by Respondent to an investigator for the Board of Registration in Nursing.

[12] Various documents were initially marked as Exhibits for Identification and subsequently admitted into evidence. Exhibits for Identification 2, 3, 4, and 7 – 11 were respectively admitted into evidence as Exhibits 6, 10, 11, 16, 18, 20, 22, and 29. Hence, the above list of Exhibits for Identification enumerates only those exhibits not subsequently entered into evidence. By error of omission, Exhibits for Identification were marked as 1- 4 and 6 -11; no document was marked as Exhibit 5 for Identification.

[13] The fax number that appears on page 1 of the document is not part of the original document and does not comprise part of the Review Examiner's decision.

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III. Findings of Fact

Preliminary Findings

1. On or about March 31, 2000, Respondent was licensed by the Board to practice as a Registered Nurse ("RN") in the Commonwealth of Massachusetts (the "Commonwealth"). Respondent's license expired on May 21, 2010 and has not been renewed. (Board records of which the Board takes administrative notice).
2. In December 1994, Respondent graduated from Central Texas College with an associate degree in nursing. He was licensed as an RN in Texas in 1995. (Testimony of Respondent; Exhibit 31)
3. At some point between 2001 and 2004, Respondent began working at Brockton Hospital ("Brockton" or the "hospital") in Brockton, Massachusetts as a travel nurse. Thereafter, Respondent was hired by Brockton as a staff nurse. Subsequently, including in January 2006, Respondent worked at Brockton on a *per diem* basis. While working at Brockton, Respondent primarily worked twelve (12) hour shifts (7:00 p.m. to 7:00 a.m.) in the Telemetry Unit, an intermediate level care unit for patients with cardiac conditions. (Testimony of Respondent; Testimony of Sturge; Testimony of Walsh; Exhibit 31)
4. As of January 2006, Respondent was certified in Advanced Cardiac Life Support ("ACLS").[14] (Testimony of Respondent)
5. Eileen Brady ("Ms. Brady") has been licensed as a Registered Nurse in the Commonwealth of Massachusetts since in or about July 2005.
6. Since May 2005, Ms. Brady has worked at Brockton Hospital, initially as an aide. Since July 2005, she has worked primarily on the Telemetry Unit, from 11:15 p.m. to 7:15 a.m. ("night shift"). With her training as a Telemetry Unit

[14] ACLS incorporates various clinical interventions for the urgent treatment of a life threatening condition, including cardiac arrest. ACLS training takes between eight (8) and sixteen (16) hours, as opposed to about three (3) hours of training for Basic Cardiac Life Support. Such training includes instruction in managing a patient's airway - intubation, initiating intravenous access, reading and interpreting electrocardiograms, and understanding emergency pharmacology. (Testimony of Sconyers; Testimony of Snydeman; Wikipedia [http://en.wikipedia.org/wiki/Advanced_cardiac_life_support]).

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nurse, Ms. Brady has also worked in the Emergency Department ("ED") and on the Medical-Surgical Unit. (Testimony of Brady; Testimony of Marks)

7. Ms. Brady trained for four and a half (4 ½) months on the Telemetry Unit under a preceptor's supervision. She also took a six (6) week telemetry course and participated in the hospital's general orientation. (Testimony of Brady)
8. Corrine Bryant ("Ms. Bryant") has been an RN licensed in the Commonwealth since 2004. (Testimony of Bryant)
9. Ms. Bryant has worked as a staff nurse on Brockton's Telemetry Unit since 2004. She had six (6) months of orientation under the supervision of a preceptor. In January 2006, Ms. Bryant worked the night shift four (4) nights a week. (Testimony of Bryant)
10. Christine Sconyers ("Ms. Sconyers") lives and works as an RN in Rhode Island, where she has been licensed to practice nursing since 2001. Ms. Sconyers holds an expired RN license in Massachusetts. (Testimony of Sconyers)
11. From approximately 2002-2005, Ms. Sconyers worked on the cardiac floor at Children's Hospital, Boston, Massachusetts. In or about June 2005, she was hired to work three (3) night shifts a week on Brockton's Telemetry Unit. (Testimony of Sconyers)
12. In January 2006, Ms. Sconyers was certified in ACLS. (Testimony of Sconyers)
13. Rosemarie Marks ("Ms. Marks") has been an RN since 1978. (Testimony of Marks)
14. Ms. Marks has been employed at Brockton Hospital since 1981, working in primarily a supervisory role for the last fifteen (15) to twenty (20) years. (Testimony of Marks)
15. In January 2006, Ms. Marks was a full-time administrative coordinator assigned as the night shift nursing supervisor for Brockton Hospital. As such, she oversaw staffing and administrative needs for the shift and served

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as an administrative and clinical resource for nurses. Ms. Marks made rounds throughout the hospital and carried a pager. (Testimony of Marks)

16. Debra Sturge ("Ms. Sturge") has been an RN since 1983. (Testimony of Sturge)

17. Ms. Sturge has worked at Brockton Hospital since 1981. Prior to becoming Nurse Manager for the Telemetry Unit in May 2005, she worked in the ED for about fourteen (14) years and in the Telemetry Unit for about seven (7) years. From 2002 – 2005, Ms. Sturge was the administrative coordinator on the Telemetry Unit. (Testimony of Sturge)

18. As Nurse Manager of the Telemetry Unit, Ms. Sturge oversees and evaluates the nursing staff, clinical care assistants, and secretaries for the unit. In January 2006, she worked full-time, from about 7:00 – 7:40 a.m. to 4:00 p.m. (Testimony of Sturge)

19. Kimberly Walsh ("Ms. Walsh") has been an RN since 1985. From 1996-2004, Ms. Walsh served as Director of Nursing for Brockton Hospital. As Vice President of Patient Services at Brockton since 2004, Ms. Walsh has been responsible for overseeing clinical operations and labor issues. (Testimony of Walsh)

20. Robert Covett, D.O. is licensed as a physician in the Commonwealth and board certified in internal medicine. Working in a group practice, he treats adult patients, including patients with cardiac conditions. (Testimony of Covett)

21. Bruce Kriegel, M.D. ("Dr. Kriegel")[15] graduated from medical school in 1983. Dr. Kriegel is licensed as a physician in the Commonwealth, with specialties in internal medicine and cardiology. At his group practice, Brockton Cardiology Associates, Dr. Kriegel has a practice of approximately 4,000 general cardiology patients. (Testimony of Kriegel)

22. On January 10-11, 2006, Patient A was a sixty-three (63) year old female patient on Brockton Hospital's Telemetry Unit. (Testimony of Brady;

[15] All references to Dr. Kriegel in this Final Decision and Order signify Dr. Bruce Kriegel. References to Dr. Andrew Kriegel are by his full name.

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Testimony of Bryant; Testimony of Kriegel; Testimony of Marks; Testimony of Respondent; Testimony of Sconyers Testimony of Sturge; Testimony of Walsh; Exhibits 3, 9, 19)

23. On January 10-11, 2006, Patient A was intellectually and mentally fully competent, alert, and knowledgeable about her medical condition. (Testimony of Brady; Testimony of Bryant; Testimony of Sconyers; Exhibit 19)

Terms Defined

24. A hospital telemetry unit is an intermediate level care unit where patients are constantly monitored for cardiac conditions. Monitoring includes checking blood pressure, oxygen saturation, and heart rates and rhythms. (Testimony of Snydeman)

25. Atrial fibrillation is a common arrhythmia (irregular rhythm) of the heart. The upper chambers of the heart, the atria, beat independently from the lower chambers of the heart, the ventricles, in a disorganized fashion. The atria are beating too rapidly (more than one hundred [100] beats per minute), and are discoordinate with the ventricles. The atria are not able to fill with blood as they do when the heart beats normally. Patients with atrial fibrillation are at risk for blood clots inside the heart that may cause strokes and other serious problems. (Testimony of Snydeman; Testimony of Kriegel)

26. Atrial fibrillation with rapid ventricular response involves a ventricular response to atrial fibrillation of more than 100 beats per minute. (Testimony of Kriegel)

27. Atrial flutter is also an arrhythmia of the heart. The heartbeat is extremely rapid, but the heart beats in a more organized and regular pattern than in cases of atrial fibrillation. (Testimony of Kriegel)

28. A sinus rhythm is a normal heart rhythm. A normal heart rate ranges from fifty (50) to one hundred (100) beats per minute. (Testimony of Kriegel)

29. When the heart pauses, or misses beats, the heart is not receiving the electrical signal to beat. A pause of three (3) seconds or more is considered abnormal. (Testimony of Kriegel)

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30. A cardiac pause that lasts eight (8) seconds is concerning in terms of its potential for danger to the patient. If the pause persists, the patient can pass out, which may lead to immediate death. In such cases, it is appropriate to review an electrocardiogram ("EKG"), to notify a physician, and perhaps ready a defibrillator for use. A change in treatment should be made to avoid harm to the patient. (Testimony of Snydeman; Testimony of Covett)

31. A sinus pause involves a single missed heartbeat. (Testimony of Snydeman)

32. A sinus arrest involves two (2) or more skipped heartbeats, with no specific duration of time between the missed beats.

33. Symptoms of pausing[16] in patients experiencing sinus pauses or sinus arrests typically include lightheadedness, dizziness, and fainting spells. (Testimony of Kriegel)

34. Asystole, or cardiac arrest, signifies the complete lack of electrical activity or any rhythm in the heart, with no resumption of a heartbeat. It is distinct from cardiac pausing, where the heart resumes beating. (Testimony of Snydeman; Testimony of Kriegel)

35. Sudden cardiac arrest signifies a sudden loss of heart function and breathing. Symptoms include loss of a palpable pulse, the absence of blood pressure, and a loss of consciousness as the result of the brain being deprived of oxygen. Sudden cardiac arrest must be treated immediately to avoid death. (Testimony of Snydeman; Testimony of Covett)

36. Brockton Hospital policy called for nurses to call a code if they believed a patient was about to become asystolic. (Testimony of Marks)

37. EKG machines and monitors may be programmed in such a way that their printouts show a patient experiencing asystole when the patient is instead having a sinus pause or sinus arrest of a certain duration that sets off an alarm. In other words, a printout from an EKG machine or monitor may not

[16] The terms cardiac pausing or cardiac pause, as used by witnesses in the instant proceeding, include sinus pauses and sinus arrests.

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be accurate in indicating that a patient experienced asystole.[17] (Testimony of Snydeman)

38. Sick Sinus Syndrome, also known as Tachy-Brady Syndrome, occurs when the sinus node in the atrium does not function normally. Patients with this syndrome are prone to experiencing alternating periods when their hearts beat excessively fast and excessively slow. The Syndrome is not caused by Cardizem, but may be treated with Cardizem.[18] (Testimony of Snydeman; Testimony of Kriegel)

39. Cardizem is a medication commonly used to slow down the heart rate. Cardizem and Amiodarone, a potent anti-arrhythmic drug, are frequently administered to treat patients with atrial fibrillation. (Testimony of Snydeman; Testimony of Kriegel)

40. Cardizem remains in a patient's system and continues to be effective for a period of time (an hour or longer) after the medication is discontinued. (Testimony of Kriegel; Testimony of Snydeman)

41. A crash cart or code cart contains medications and equipment, including a defibrillator, necessary for advanced cardiac life support. (Testimony of Snydeman; Testimony of Sconyers; Testimony of Respondent)

42. An order for an Intravenous ("IV") Hep Lock calls for maintaining access to the patient's circulation in the event that a physician orders an IV medication or fluids be administered to the patient. Its sole purpose is to provide such access. If the physician orders an IV medication or fluids, the hep lock is immediately converted to the infusion prescribed by the physician. (Testimony of Kriegel; Testimony of Sconyers, Testimony of Sturge)

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[17] Nursing Supervisor Rosemarie Marks testified that monitors and printouts on the Telemetry Unit indicated asystole after a pause of a certain length even though the patient was not asystolic. In such instances, the nurse or doctor would ascertain whether the patient was actually asystolic by observing the patient and reviewing the printout. (Testimony of Marks)

[18] Patients with Sick Sinus Syndrome are frequently sensitive to medications that slow the heart rate and may have an unexpectedly dramatic response to such medications. In such cases, pacemakers may be inserted to control the heart rate, enabling the patient to tolerate medication which slows the heart rate. (Testimony of Kriegel)

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43. At Brockton Hospital, intravenous access was continually maintained for all Telemetry Unit patients so as to be immediately available when needed. (Testimony of Sturge)

Expert Witness

44. On behalf of the Prosecution, Colleen Snydeman (Ms. Snydeman), R.N., testified as an expert in the standards of nursing practice that apply on an inpatient hospital telemetry unit. (Testimony of Snydeman)

45. Ms. Snydeman has been licensed as an RN in the Commonwealth since 1981. (Testimony of Snydeman)

46. Ms. Snydeman has a Bachelor of Science in nursing from Northeastern University and a Master of Science in forensic nursing from Fitchburg State College. (Testimony of Snydeman; Exhibit 26)

47. Ms. Snydeman is employed as the nursing director of the Cardiac Care Unit at Massachusetts General Hospital ("MGH"). As such, she directs and oversees the care of sixteen patients in a critical care environment and insures that the approximately 65 nurses who report to her are safe and competent to practice. Atrial fibrillation is a routine diagnosis on the MGH Cardiac Care Unit. (Testimony of Snydeman; Exhibit 26)

48. Ms. Snydeman began her career at MGH as a staff nurse in the Burn Unit and the Surgical Intensive Care Unit. For fifteen (15) years, she was a Clinical Nursing Supervisor responsible for supervising between twelve (12) and twenty-two (22) patient care units, among other duties. Ms. Snydeman has also held the positions of Nursing Director of the Respiratory Acute Care Unit, Nurse Manager of the Thoracic Surgical Unit, and Interim Nurse Manager of two (2) pediatric units. In 1994 – 1995, Ms. Snydeman was the Nurse Manager at Metro-West Medical Center ("Metro West") in Framingham and Natick, Massachusetts. Ms. Snydeman was responsible to the Director of Nursing for the overall management of patient care at both the Framingham and Natick sites. Ms. Snydeman has precepted staff nurses as well as clinical nursing supervisors and nursing directors. (Testimony of Snydeman; Exhibit 26)

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49. Ms. Snydeman has chaired and co-chaired numerous committees at MGH. Currently, she co-chairs the Critical Care Committee, the Code and Emergency Response Committee, and the Rapid Response Implementation Task Force ("Task Force"). Pursuant to the goals of the Joint Commission on National Patient Safety, the Task Force focuses on improving hospital wide recognition of and response to a patient's deteriorating condition. (Testimony of Snydeman; Exhibit 26)

50. Ms. Snydeman has been the Principal Investigator ("PI") and Co-PI on several research projects and has done both poster and oral presentations. (Testimony of Snydeman; Exhibit 26)

51. In 2008, Ms. Snydeman was among the authors on an article published in the nursing journal *Heart and Lung* entitled "A Model of Recovering Medical Errors in the Coronary Care Unit". The article was based on a qualitative review of nurses' experiences with intercepting medical errors and "near miss events." (A "near miss event" involves the prevention of medical errors as well as the recognition and interruption of medical errors). (Testimony of Snydeman; Exhibit 26)

52. In preparation for her testimony before the Board, Ms. Snydeman reviewed various documents, including the First Amended Order to Show Cause issued in the instant matter; Respondent's Answer to the First Amended Order to Show Cause; medical records for Patient A for two (2) inpatient admissions to Brockton Hospital from January 10–12, 2006 and January 15-19, 2006; attachments to a complaint filed with the Board against Respondent's nursing license by Kimberly Walsh, R.N.; an affidavit and resume submitted to the Board by Respondent; and a statement written by Eileen Brady, R.N. (Testimony of Snydeman)

Standards of Practice

53. Ms. Snydeman identifies sources of standards of practice for nurses practicing on an inpatient telemetry unit as including the American Nursing Association, the American Association of Critical Care Nurses, the

Massachusetts Board of Registration in Nursing, and other professional organizations. (Testimony of Snydeman)

54. Accepted standards of nursing practice prohibit nurses from diagnosing patients and from discussing their perception of a patient's diagnosis with the patient. A nurse who has concerns about a suspected diagnosis may consult with the patient's physician. (Physicians are authorized to render diagnoses). (Testimony of Snydeman)

55. Accepted standards of nursing practice prohibit nurses from ordering medication and making changes in a patient's medication orders without obtaining an order from a physician or other authorized prescriber. (Testimony of Snydeman)

56. Accordingly, nurses lack the authority to order other nurses to discontinue or alter a medication being administered to a patient pursuant to a physician's order. This holds true even where a nurse suspects the patient may be allergic to the prescribed medication. (Testimony of Snydeman)

57. Accepted standards of nursing practice require nurses to act in a respectful, collaborative, and professional manner. Such standards of practice promote better patient outcomes. (Testimony of Snydeman)

58. In accordance with accepted standards of nursing practice, when a nurse has concerns about medication being administered to a patient assigned to another nurse (hereinafter "assigned nurse" or "primary nurse"), the concerned nurse (hereinafter "second nurse") should seek more information from the assigned nurse, including a clear understanding of the patient's history, background, condition, and plan of care. The conversation should be conducted in a respectful, collaborative manner, consistent with the best interests of the patient. (Testimony of Snydeman)

59. Pursuant to accepted standards of nursing practice, after speaking with the assigned nurse, a second nurse with lingering concerns that a patient is being harmed by a medication is required to pursue her concerns through the nursing chain of command. Initially, the second nurse should approach the charge nurse on the unit. If dissatisfied with that interaction, the second

nurse should speak with a nursing supervisor or manager, even if that person is not on duty and is off site. If the nurses' concerns remain unresolved, she may contact a physician. (Testimony of Snydeman)

60. In accordance with accepted standards of nursing practice, on a telemetry unit, a second nurse may assess a patient assigned to another nurse at the request of the assigned nurse, or when the second nurse responds to a monitor alarm,[19] or when the patient requests assistance while the assigned nurse is unavailable to respond. (Testimony of Snydeman)

61. Accepted standards of nursing practice allow a second nurse to inquire of a primary nurse whether she needs assistance in responding to a patient whose alarm has sounded. The second nurse may ask the patient questions if the primary nurse is unavailable or not present. (Testimony of Snydeman)

62. When a patient experiences cardiac pausing, an experienced nurse who is not assigned to the patient, may give the assigned nurse advice if the latter is less experienced and not able to properly assess the situation. In keeping with accepted standards of nursing practice, the more experienced nurse may not render a diagnosis of the patient or give the assigned nurse medication orders. (Testimony of Snydeman)

63. In accordance with accepted standards of nursing practice, when a telemetry unit patient experiences a cardiac pause, the nurse caring for the patient is required to assess the patient, including insuring that the patient's mental status is alert and oriented and inquiring whether the patient experienced any symptoms related to the pausing.[20] The nurse should "probably" do an EKG. The nurse should notify a physician of the patient's

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[19] According to Ms. Sconyers and Ms. Walsh, when a patient's alarm sounded at the Telemetry Unit's nurses' station and the nurse assigned to the patient was not present or available, another nurse would check the patient to be sure the patient was safe. Once having checked the patient, that nurse would advise the assigned nurse of the situation. (Testimony of Sconyers; Testimony of Walsh)

[20] Ms. Snydeman testified that patients' reactions to cardiac pauses range from not experiencing symptoms and being unaware of the pause to blacking out and becoming unresponsive. The type of neurological assessment a nurse performs following a cardiac pause is related to the level of the patient's reaction. If a nurse is with an alert and oriented patient during a cardiac pause and observes no changes in the patient during and after the pause, it may not be necessary to do an extensive neurological assessment of the patient. However, if the patient becomes temporarily unresponsive, a more detailed neurological assessment would include such measures as checking pupils, checking hand strength, and looking for changes in facial expression. (Testimony of Snydeman)

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pausing and document in the patient's medical record the occurrence of the pause; the length of the pause; and her assessment of the patient, including the patient's vital signs. The nurse may attach to the medical record a hard copy of the monitor strip showing the pause. (Testimony of Snydeman)

64. If a patient experiences a loss of consciousness with a cardiac pause, accepted standards of nursing practice require the nurse caring for the patient to invoke basic life support measures, including checking for a pulse and a clear airway, summoning help, and performing cardiopulmonary compressions. (Testimony of Snydeman)

65. In the case of a cardiac pause lasting eight (8) seconds, or in the case of a patient on Cardizem experiencing sinus arrest, accepted standards of nursing practice dictate obtaining and reviewing an EKG for additional information about the pause[21] and notifying a physician. It may be appropriate to have a defibrillator ready for use. (Testimony of Snydeman)

66. In accordance with accepted standards of nursing practice, a nurse is required to create a comforting, therapeutic environment for patients. Nurses should exhibit confidence, competence, caring, and compassion. Conduct that induces or increases patients' anxiety is inappropriate. Patients pick up on signs of a caregiver's anxiety. (Testimony of Snydeman)

67. Unless a patient raises the issue of seeing a white light, nurses violate accepted standards of nursing practice by asking a patient whether the patient has seen a white light. Such a question does not constitute a part of

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[21] During Ms. Snydeman's testimony, there was questioning regarding the need to do a twelve (12) lead EKG on Patient A. (A twelve (12) lead EKG looks at the heart from twelve (12) different angles and is the "gold standard" of EKGs). Although Ms. Snydeman's testimony did not reflect clear standards of care for the performance of twelve (12) lead EKGs on patients in Patient A's situation, Ms. Snydeman stated she would have expected a twelve (12) lead EKG to have been done before and after Patient A's Cardizem was discontinued, if the equipment was available. According to Ms. Snydeman, most hospital telemetry units have limited numbers of twelve (12) lead EKG machines and do not have the capacity to perform twelve (12) lead EKGs with each sinus arrest. (Twelve lead EKGs were done on Patient A on January 11, 2006 following pausing at 2:05 a.m. and 4:00 a.m. However, the record contains no evidence as to why twelve (12) lead EKGs were done at these times and not done at others and what the availability of twelve (12) lead EKG machines was in the Telemetry Unit. Ms. Snydeman saw no evidence in the record of any requirements or protocols at Brockton Hospital requiring the performance of twelve [12] lead EKGs following a sinus arrest). (Testimony of Snydeman)

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a neurological or other nursing assessment. It may induce or exacerbate anxiety in a patient and is at odds with a nurse's duty to create a comforting , therapeutic environment for the patient. (Testimony of Snyderman)

68. Similarly, a nurse acts unprofessionally and violates the duty to create a comforting, therapeutic patient environment when the nurse announces within earshot of a patient that the patient is experiencing sudden cardiac death. (Testimony of Snyderman)

69. Accepted standards of nursing practice require nurses to document in a patient's medical record telephone orders that a physician gives the nurse for that patient. Among other places, the order should be documented as a telephone order on the physician's order sheet, with the date and time noted. Both the nurse and the physician ordering the medication should sign the order.[22] (Testimony of Snyderman)

70. In keeping with the requirement for nurses to interact in a respectful, collaborative, and professional manner, a nurse violates accepted standards of nursing practice by making derogatory comments about nursing colleagues. (Testimony of Snyderman)

71. A nurse violates accepted standards of nursing practice by describing a nursing colleague as a "gutter whore" or "hospital whore" or as a "dominatrix". In a letter written by a nurse to a hospital administrator, the use of such terms and/or profanity falls below accepted standards of nursing practice. Likewise, references to colleagues' sexual preferences or habits violate accepted standards of nursing practice. (Testimony of Snyderman)

Brockton Hospital's Telemetry Unit

72. Brockton Hospital's Telemetry Unit, also known as B2, was a twenty-one (21) bed unit with a generally full patient census. (Testimony of Brady; Testimony of Sturge)

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[22] Pursuant to Brockton Hospital policy, nurses receiving verbal or telephone medication orders from a physician were required to document the orders on the physician order sheet, noting that the order was given as a telephone or verbal order, and noting the date and time of the order. Either the ordering physician or another physician attending the patient was required to sign the order. (Testimony of Brady; Testimony of Covett; Testimony of Sturge; Testimony of Walsh)

73. With a full census, the unit was staffed by five (5) RNs on the day and evening shifts and by four (4) RNs on the night shift. A Clinical Care Assistant assisted the nurses with such tasks as taking vital signs twice a shift, cleaning and turning patients, and responding to call bells. (Testimony of Brady; Testimony of Sturge)
74. Nurses on the Telemetry Unit cared for a maximum of six (6) patients. On the night shift, three (3) nurses were assigned to five (5) patients and a fourth nurse was assigned to six (6) patients. (Testimony of Brady; Testimony of Sturge)
75. Beginning Telemetry Unit nurses worked with preceptors for a period of up to six (6) months. The length of the training period varied with the particular nurse's skill. All Telemetry Unit nurses were trained to detect and treat arrhythmias, and to handle defibrillators and pacemakers. (Testimony of Marks; Testimony of Sturge)
76. The Telemetry Unit nurses frequently care for patients with arrhythmias, including atrial fibrillation. As a Telemetry Unit nurse, Ms. Brady was trained to care for a patient such as Patient A. (Testimony of Brady; Testimony of Sturge)
77. All patients on the Telemetry Unit wore monitors that measured heart rate, rhythms and arrhythmias, oxygen saturation levels, and blood pressure. The monitor screens were located in and viewed only at the nurses' station. (Testimony of Brady; Testimony of Sturge)
78. The monitors would set off alarms when certain changes occurred in a patient's condition, including irregular heart rates and cardiac pausing. The alarms made various sounds that corresponded to the event that set off the alarm. In other words, there would be one sound for a slow heart, another sound for a fast heart rate, and still another sound for an arrhythmia. (Testimony of Brady; Testimony of Sturge)
79. When an alarm sounded, nurses were required to respond immediately by assessing the patient and determining what triggered the alarm. (Testimony of Brady; Testimony of Sturge)

80. Monitor alarms sounded frequently on the Telemetry Unit. (Testimony of Bryant; Testimony of Sconyers)

81. The Critical Care Unit ("CCU") had a lower patient/nurse ratio than the Telemetry Unit and CCU nurses were able to provide closer patient monitoring and certain treatment that was not available on the Telemetry Unit. (Testimony of Brady; Testimony of Marks; Testimony of Sconyers)

82. Nurses from the Telemetry Unit had training and qualifications in patient care that enabled them to safely transport patients from the Telemetry Unit to the Critical Care Unit. (Testimony of Marks)

Patient A's Condition and Care: January 10-12, 2006 and January 15-18, 2006

83. On January 10, 2006, Patient A was a 63 year old woman with a history of coronary artery disease and recurrent atrial fibrillation. Although in 2004, Patient A had heart bypass surgery, in January 2006, she was otherwise healthy and "fairly active". Her daily prescription and non-prescription medications were Amiodarone (for atrial fibrillation), Lipitor to lower cholesterol, Synthroid to control hypothyroidism, and aspirin (81 mg/day). (Testimony of Kriegel; Exhibits 9, 19)

84. On January 10, 2006, Patient A presented to Brockton Hospital's Emergency Department ("ED") after experiencing heart palpitations and some light-headedness and shortness of breath. There, she was evaluated by a cardiologist, Dr. Bruce Kriegel, and diagnosed with atrial fibrillation with a rapid ventricular response. She had a rapid heart rate of between 110 – 120 beats per minute. (Testimony Kriegel; Testimony Snyderman; Exhibits 6, 9, 19)

85. In the ED, a 20 mg bolus of Cardizem was administered to Patient A. Thereafter, Patient A was put on an intravenous ("IV") Cardizem drip, 10 ml per hour.[23] (Testimony of Brady; Testimony of Sconyers; Exhibit 6)

[23] As noted above, Patient A was already taking Amiodarone on a daily basis. (Testimony of Kriegel; Exhibits 9, 14, 19)

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86. Patient A was admitted from the ED to the Telemetry Unit. At the time of her admission, Patient A continued to receive an IV Cardizem drip at the rate of 10 ml per hour. (Testimony of Brady; Exhibit 8/14)

87. Patient A was in Room 207, between forty and fifty feet down the hall from the nurses' station and next to a set of double doors that led to elevators. Her bed was situated closest to the door. (Testimony of Brady, Testimony of Bryant; Testimony of Sconyers: Exhibits 9, 29)

88. Ms. Brady was assigned to care for Patient A, as well as for four (4) other patients. Other than Patient A, none of Ms. Brady's patients experienced an emergent situation. A nursing assistant, Nanette Dookhran, and three other nurses – Respondent, Ms. Bryant, and Ms. Sconyers – also staffed the Telemetry Unit on the night shift of January 10 -11, 2006.[24] Ms. Bryant was the charge nurse that night, and Ms. Marks, the night nursing supervisor, was Ms. Bryant's supervisor. (Testimony of Brady, Testimony of Bryant; Testimony of Marks; Testimony of Respondent; Testimony of Sconyers; Exhibits 3, 4, 5, 7, 9, 16)

89. Ms. Brady was qualified and competent to care for Patient A. She had cared for many patients with the same diagnosis. On the basis of her knowledge and that experience, she felt comfortable and confident caring for Patient A. At various times, she conferred with Ms. Sconyers and Ms. Bryant about her care of Patient A. (Testimony of Brady; Testimony of Bryant; Testimony of Sconyers; Testimony of Sturge)

90. Assessing Patient A at the beginning of her shift, Ms. Brady found Patient A to be alert and oriented. (Testimony of Brady)

91. At or about 11:38 p.m. on January 10, 2006, Patient A experienced an eight (8) second cardiac pause ("pause 1"). (Testimony of Brady; Testimony of Covette; Exhibits 4,16[25])

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[24] Two other nurses were being oriented to the Telemetry Unit, but had no patient assignments. (Testimony of Brady; Testimony of Respondent)

[25] Various EKGs/monitor strips showing Patient A's heart pausing are present in Patient A's medical record. The parties stipulated and Dr. Kriegel testified that certain EKGs/monitor strips are cut off and may not show the full length of the pauses. (Testimony Kriegel)

A had experienced an eight (8) second cardiac pause; b) Patient A was asymptomatic during the pause; c) Patient A's vital signs were stable, she was alert and awake, and her heart rate had returned to over 100;[29] and d) Patient A was on Amiodarone and 10 ml per hour of IV Cardizem to slow down the ventricular response rate to the atrial fibrillation. (Testimony of Brady; Testimony of Bryant; Testimony of Covett; Testimony of Sconyers; Exhibit 4)

96. Dr. Covett gave Ms. Brady a telephone order to decrease Patient A's Cardizem by half, to 5 ml per hour, and to discontinue the Cardizem in the event that Patient A experienced additional pausing. Concerned that Patient A's underlying condition made her sensitive to Cardizem, Dr. Covett hoped that decreasing or arresting the administration of the medication to Patient A would prevent further pausing.[30] According to Dr. Covett and Dr. Kriegel, the pausing Patient A experienced was serious but not unusual for a patient with arrhythmias, including atrial fibrillation. (Testimony of Brady; Testimony of Covett; Testimony of Kriegel; Exhibits 4, 5)

97. Ms. Brady failed to document Dr. Covett's order on the Physician's Order Form in Patient A's medical record. However, the Progress Note written by Ms. Brady in Patient A's record reflects a new order from Dr. Covett to decrease Patient A's Cardizem to 5 ml per hour and to discontinue the medication in the event of any additional pauses. According to Dr. Covett, the note accurately reflects the order he gave Ms. Brady with respect to Patient A's care. (Testimony Brady; Testimony of Covett; Exhibits 4, 8/14)

98. Immediately following her conversation with Dr. Covett, Ms. Brady decreased Patient A's Cardizem drip from 10 ml to 5 ml per hour.[31] (Testimony of Brady; Exhibit 5)

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[29] Dr. Covett testified that patients may maintain normal vital signs when experiencing cardiac pauses. He noted that apart from the loss of pulse, there is no indication that Patient A experienced irregular vital signs during the eight (8) second pause. She had no significant drop in blood pressure and she was awake and alert throughout the episode. (Testimony Covett)

[30] Dr. Covett stated that administering a combination of Amiodarone and Cardizem to Patient A caused a very slow heart beat, which contributed to Patient A's pausing. (Testimony Covett)

[31] Ms. Brady also paged Ms. Marks, the hospital's night nursing supervisor, to make her aware of Patient A's status and Dr. Covett's instructions. (Testimony of Marks; Testimony of Sconyers)

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99. At around 1:00 a.m., Patient A experienced another cardiac pause ("pause 2"). A 2.5 second pause was followed by a single beat, which was followed by a 3.5 second pause.[32] (Testimony of Brady; Testimony of Kriegel; Exhibit 4)

100. Ms. Brady immediately went to Patient A's room, assessed her, and shut off the Cardizem drip in accordance with Dr. Covett's order. With Ms. Sconyers assistance in flushing the IV line, Ms. Brady disconnected and capped off the empty IV line. Ms. Brady believes that the bag of Cardizem continued to hang from the pump next to Patient A, but she knows that the medication was not being infused. (Testimony Brady; Testimony Sconyers;[33] Exhibits 4, 5)

101. The Telemetry Flow Sheet documented by Ms. Brady on January 10-11, 2006, reflects the following relative to the administration of Cardizem to Patient A: flowing at 10 ml per hour at 23:00 p.m. (1/10); flowing at 5 ml per hour at 23:38 p.m. (1/10); and discontinued at 00:58 a.m. (1/11). (Exhibit 5)

102. As with the first pause, upon assessment, Patient A was asymptomatic relative to the second pause. Her vital signs were stable. (Testimony Brady; Exhibits 4, 10, 30)[34]

103. After assessing Patient A, Ms. Brady called Dr. Kriegel to inquire whether he had additional instructions and orders regarding Patient A's care. He had none and stated that he would see Patient A in the morning. Ms. Brady felt

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[32] At the hearing, the 2.5 and 3.5 second pauses were referred to as Patient A's second pause.

[33] Both Ms. Brady and Ms. Sconyers testified that Ms. Sconyers flushed the IV line and assisted Ms. Brady in shutting off the flow of Cardizem to Patient A. In testifying about the events that occurred with respect to Patient A on the night of January 10-11, 2006, Ms. Sconyers acknowledged that she did not recall the precise times when certain events occurred. It appeared that there was some merger and integration of Ms. Sconyers memories regarding the events surrounding Patient A's first and second cardiac pauses that night. (For instance, Ms. Sconyers believed that Ms. Brady woke Patient A before assessing Patient A after her first pause as opposed to subsequent pauses when the record shows it is likely Patient A was asleep). However, Ms. Sconyers had a clear recollection of flushing the line and assisting Ms. Brady in discontinuing the administration of Patient A's IV Cardizem. (Testimony Brady; Testimony Sconyers)

[34] Ms. Sconyers also testified that upon assessing Patient A with Ms. Brady, Patient A appeared asymptomatic, alert and conversing. However, it was not clear from Ms. Sconyers testimony whether her memory of Patient A's status related to the first pause or the second pause or both. (Testimony of Sconyers)

Ms. Bryant also lacked memory about the timing of various events and her own and her colleagues' whereabouts at certain points during the night in question. Ms. Bryant did not recall whether she went to Patient A's room when Patient A experienced pause 2. (Testimony of Bryant)

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reassured that Dr. Kriegel was satisfied with the care Patient A was receiving. (Testimony of Brady; Testimony of Kriegel; Exhibit 4)[35]

104. Just after 2:00 a.m. on January 11, 2006, Patient A experienced a third cardiac pause, lasting about six (6) seconds ("pause 3"). (Testimony of Brady; Exhibit 4, 16)[36]

105. Upon assessment, Patient A's vital signs were normal. Ms. Brady's progress notes state that Patient A experienced some dizziness, which resolved spontaneously. (Testimony of Brady; Exhibits 4,10,30)

106. Following Patient A's third pause, Ms. Brady asked Dr. Qubti, the medical resident on the Critical Care Unit ("CCU"), to assess whether Patient A required the closer monitoring that was available in the CCU.[37] Dr. Qubti directed that Patient A remain on the Telemetry Unit. (Testimony of Brady; Testimony of Bryant; Testimony of Sconyers; Exhibit 4)

107. As Patient A appeared nervous, Ms. Brady obtained an order from Dr. Qubti for Patient A to receive a dose of IV Ativan.[38] Ms. Brady administered the Ativan to Patient A at 2:30 a.m. Patient A had received a scheduled dose of 0. 5 mg Ativan for anxiety at 12:30 a.m. (Testimony Brady; Exhibits 3, 7, 9)

108. Ms. Brady's progress note reflects that Ms. Brady and Ms. Dookrhan checked Patient A every fifteen (15) minutes following her third cardiac pause, shortly after 2:00 a.m. (Exhibit 4)

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[35] Dr. Kriegel, who had no memory of the events involving Patient A on the night of January 10-11, 2006, testified that he interpreted Ms. Brady's note stating that he gave no new orders to mean that he agreed with Dr. Covett's order to decrease, and with further pauses, to discontinue Patient A's Cardizem drip. (Testimony of Kriegel)

Ms. Bryant recalled that at some point during the night in question, she spoke with Ms. Brady about calling Patient A's cardiologist. Ms. Bryant recalled two (2) telephone conversations regarding Patient A between Ms. Brady and physicians and also recalled Dr. Qubti, the medical resident on the CCU, evaluating Patient A. (Testimony of Bryant)

[36] Without providing greater detail, Ms. Sconyers testified that Patient A continued to experience pausing after the Cardizem was discontinued. Ms. Sconyers recalled that Patient A had a pause about an hour after the medication was shut off. As the Cardizem was discontinued at about 1:00 a.m. and Patient A's third pause occurred shortly after 2:00 a.m., the Board infers that Ms. Sconyers testimony referred to the third pause. (Testimony of Sconyers)

[37] CCU nurses were assigned to just two (2) patients at a time. Additionally, the CCU offered external pacing of the heart (similar in function to a pacemaker), which was not available in the Telemetry Unit. (Testimony of Brady)

[38] Ms. Brady documented the order on the Physician's Order Form and Dr. Qubti signed the order. (Testimony of Brady; Exhibit 7)

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109. At some point between 4:00 a.m. and 4:30 a.m., Patient A experienced a fourth cardiac pause, lasting eight (8) seconds ("pause 4"). (Testimony of Brady; Exhibit 4, 16)

110. Ms. Brady immediately assessed Patient A. Her vital signs were normal and stable; however, she complained of feeling flush. (Testimony of Brady; Exhibits 4, 10, 30)

111. At Ms. Brady's request, Dr. Qubti assessed Patient A and ordered Patient A's transfer to the CCU for closer monitoring. A transfer note written by Dr. Qubti, dated January 11, 2006, recounts Patient A's four (4) cardiac pauses and notes that with the last pause at about 4:00 a.m., Patient A experienced symptoms of "lightheadedness and vision changes."[39] (Testimony of Brady; Testimony of Sconyers)

112. At 5:00 a.m., Ms. Brady administered IV Ativan to Patient A pursuant to a verbal order from Dr. Qubti.[40] (Testimony of Brady; Exhibit 9)

113. Following her transfer to the CCU between 5:00 and 5:30 a.m., Patient A remained stable and did not experience any cardiac pauses. (Testimony of Marks; Exhibits 6, 18)

114. On January 11, 2006, Dr. Kriegel evaluated Patient A in the CCU. Patient A was alert and oriented. According to Dr. Kriegel's progress note, he diagnosed Patient A with atrial fibrillation/flutter and recommended maintaining Patient A on Amiodarone and sending her to Boston Medical Center ("BMC") for a procedure known as radiofrequency ablation ("RF ablation" or "ablation") to restore the normal rhythm of her heart.[41] (Testimony Kriegel; Exhibit 18)

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[39] Dr. Qubti's 5:00 a.m. transfer note is not in evidence, but some of its contents were read into the record during Ms. Brady's testimony. Dr. Qubti assessed Patient A sometime after Ms. Brady assessed her immediately following her fourth pause. At that time, Ms. Brady found Patient A to be stable, except for Patient A's complaints of feeling flush. Ms. Brady did not observe and was not told by Patient A that she felt lightheaded and was experiencing vision changes. (Testimony of Brady; Exhibits 3, 4)

[40] Ms. Brady noted the administration of Ativan at 5:00 a.m., just before Patient A was transferred to the CCU, on Patient A's MAR, but failed to document the order on the Physician's Order Form (where she had transcribed Dr. Qubti's earlier order for Ativan at 2:30 a.m.) (Exhibits 7, 9)

[41] RF ablation is an invasive procedure that involves identifying and irradiating irritable areas of the heart that cause abnormal rhythms. The abnormal circuit of the heart is cauterized to preclude it from causing abnormal heart rhythms. (Testimony Covett; Testimony Kriegel)

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115. In accordance with Dr. Kriegel's recommendation, Patient A was transferred to BMC for an ablation procedure performed on January 12, 2006. Patient A was discharged to her home the following day. (Testimony Kriegel; Testimony Sturge; Exhibits 6, 18, 20, 25)

116. On January 15, 2006, Patient A experienced palpitations and was again admitted to Brockton Hospital for atrial fibrillation. Dr. Andrew Kriegel[42] evaluated Patient A and diagnosed her with Tachy–Brady Syndrome and paroxysmal (periodic, self-correcting) atrial fibrillation.[43] Dr. Andrew Kriegel recommended insertion of a permanent pacemaker. (Testimony Kriegel; Exhibit 20)

117. Dr. Andrew Kriegel also observed that Patient A was experiencing symptomatic cardiac pauses lasting up to five (5) seconds. Symptoms of pausing include lightheadedness, dizziness, and fainting episodes. (Testimony of Kriegel)

118. On January 16, 2006, Dr. Bruce Kriegel examined Patient A at Brockton Hospital. He, too, diagnosed her with Sick Sinus Syndrome with paroxysmal atrial fibrillation and pauses lasting up to five (5) seconds. Dr. Kriegel concurred with his brother's recommendation that Patient A receive a permanent pacemaker. (Testimony Kriegel; Exhibit 21)

119. On January 17, 2006, Patient A had a permanent pacemaker inserted. Cardizem was ordered to control Patient A's heart rate given her diagnosis of atrial fibrillation. (Testimony Kriegel; Exhibits 22, 23)

120. On January 18, 2006, Dr. Kriegel evaluated Patient A and observed that she continued to experience paroxysmal atrial fibrillation with rapid

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[42] Dr. Andrew Kriegel is Dr. Bruce Kriegel's brother and is also a partner in Brockton Cardiology Associates. Dr. Kriegel testified that there are any number of reasons why his brother, rather than he, would have seen Patient A on January 15, 2006, including that Dr. Andrew Kriegel was assigned to the hospital that day or was covering for Dr. Bruce Kriegel while he was away or unavailable. (Testimony of Kriegel)

[43] Patients with Tachy-Brady Syndrome, also known as Sick Sinus Syndrome, experience periods when their hearts beat either too slowly or too quickly. Such patients are sometimes very sensitive to medications that slow their heart rates and may have an exaggerated response to such medications. When medication fails, patients may get pacemakers to prevent their hearts from slowing down too much when taking medication for such conditions as atrial fibrillation. Paroxysmal atrial fibrillation is periodic and self correcting in that the heart returns to a normal sinus rhythm. (Testimony Kriegel)

ventricular response. With the pacemaker, Patient A was no longer experiencing pausing. Dr. Kriegel ordered various medications for Patient A (including the resumption of her Amiodarone) and noted that she might require a procedure known as AV nodal ablation if medication failed to control her heart rate. As it turned out, Patient A did not need an AV nodal ablation. (Testimony Kriegel; Exhibit 22)

121. On January 18, 2006, Dr. Kriegel discontinued Patient A's order for Cardizem. Although, Dr. Kriegel doesn't recall the specific circumstances, he testified that he would have discontinued the Cardizem with Patient A converting back to a normal heart rate. (Testimony Kriegel; Exhibit 24)

122. Dr. Kriegel continues to see Patient A twice a year in his cardiology practice. Her condition has remained stable since she received the pacemaker. (Testimony Kriegel)

123. Patients with Tachy-Brady Syndrome may have exaggerated responses to drugs used to slow the heart rate, including, but not limited to, Cardizem. Such drugs may exacerbate patients' slow heart rhythms. (Testimony Kriegel)

124. Before the insertion of Patient A's pacemaker, any drug administered for the purpose of slowing Patient A's heart rate could have contributed to her cardiac pauses. Cardizem was no less safe for Patient A than other such drugs.[44]

125. While Patient A did not have a heart attack or experience cardiac arrest on the night in question, her pauses were concerning. Discontinuing Patient A's Cardizem in accordance with Dr. Covett's order was an appropriate response to her pauses. (Testimony Kriegel)

Respondent's Conduct on January 10-11, 2006

[44] A hospitalist's progress note at the time of Patient A's admission to Brockton Hospital on January 15, 2006, stated that Patient A was allergic to Cardizem, Dr. Kriegel testified that Patient A was not allergic to Cardizem and the note was incorrect. (Nor did Patient A receive an overdose of Cardizem according to Dr. Kriegel). Rather, with Tachy-Brady Syndrome, Patient A had an exaggerated response to the medication. Had Patient A been allergic to Cardizem, Dr. Kriegel would not have been able to prescribe the medication for her after the insertion of her pacemaker, when her heart rate was controlled and pauses were no longer a concern. (Testimony Kriegel; Exhibit 25)

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126. On the night of January 10 -11, 2006, Respondent conducted himself in an inappropriate and unprofessional manner by: 1) asking Patient A whether she had seen a "white light" following her initial cardiac pause at or about 11:38 p.m., and 2) by pacing through the corridor abutting patients' rooms, including Patient A's room, loudly proclaiming that Patient A was experiencing or going into "sudden death". (Testimony of Brady; Testimony of Bryant; Testimony of Sturge; Testimony of Respondent)

127. According to Ms. Brady, at some point after Patient A's first cardiac pause and the reduction of her Cardizem infusion from 10 ml per hour to 5 ml per hour, Respondent approached Ms. Brady at the nurses' station. Respondent contended that Patient A had reported seeing a "white light" when he inquired of her whether she had seen a "white light" during her cardiac pause. Respondent stated that he once had a patient who had seen a white light just before passing away. (Testimony of Brady)

128. Ms. Brady further testified that she advised Respondent that she was with Patient A when her heart paused and that Patient A, who was alert, stable, and asymptomatic, gave no indication of seeing a white light. Ms. Brady found Respondent's conduct with Patient A inappropriate and his account of the patient who passed away upsetting, as she understood Respondent to imply that Patient A would pass away. (Testimony of Brady)

129. According to Ms. Brady, between pauses 1 and 2, Respondent became increasingly agitated when he learned that pursuant to Dr. Covett's order, Patient A was still receiving a decreased dose of 5 ml per hour of Cardizem. Respondent asserted that the medication should have been discontinued as it was causing "sudden death". Over a period of time, Respondent continued to rant about Patient A and "sudden death" while pacing through the hallway, outside patients' rooms.[45] In a noticeable and agitated manner,

[45] Ms. Brady testified that she was at the nurses' station when she first heard Respondent "ranting" in the hallway about "sudden death," after he learned that Patient A's Cardizem had been decreased rather than discontinued. Respondent continued his expressions of "sudden death" at random times during the night. Ms. Brady noted that although Respondent had his own patient assignments, he was in and out of the unit all night, taking smoking breaks and walking up and down

Respondent moved equipment, including the defibrillator, just outside Patient A's room. Ms. Brady was concerned that the commotion Respondent was causing outside Patient A's room would upset her.[46] (Testimony of Brady)

130. According to Ms. Brady, after pause 4, as she prepared Patient A for transfer to the CCU, Respondent came into the room and "took over". He unplugged Patient A's bed and set her up to move, acting in a rushed and urgent manner. Ms. Brady found Respondent's behavior inappropriate given that Patient A was stable and had just been assessed by Dr. Qubti. While Ms. Brady felt it was important to move Patient A to the CCU "in a timely fashion," the situation was not urgent and she wanted to keep Patient A as calm as possible. (Testimony of Brady)

131. On the morning of January 11, 2006, Ms. Brady reported Respondent's behavior to the nurse manager, Ms. Sturge. She related Respondent's white light inquiry and proclamations of "sudden death" in the corridor. Ms. Brady described Respondent's behavior as erratic and unprofessional, and stated that Respondent had inserted himself into a situation that was under control. Upset by Respondent's conduct, Ms. Brady believed Respondent had increased Patient A's anxiety. (Testimony of Brady; Testimony of Sturge; Exhibit 3)

132. Both Ms. Bryant and Ms. Sconyers testified that they heard Respondent ask Patient A whether she had seen a white light and talk about "sudden death". Ms. Bryant described Respondent's behavior as "hyper" and Ms. Sconyers stated that Respondent was loud and gesturing with his hands, acting in a manner that was "annoying", "inappropriate", and detrimental to a therapeutic patient environment. (Testimony of Bryant; Testimony of Sconyers)

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the hallway. According to Ms. Brady, Respondent was acting agitated and dramatic, flailing his arms and speaking rapidly. (Testimony of Brady)

[46] At this time, Patient A was stable and being closely monitored by Ms. Brady in accordance with Dr. Covell's orders. (Testimony of Brady)

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133. According to Ms. Bryant, her best recollection is that following Patient A's first pause, she and Respondent were standing in the doorway of Patient A's room when Respondent asked Patient A whether she had seen a white light. Ms. Bryant also heard Respondent utter something to the effect of "This is what happens with Cardizem, sudden death." (Testimony of Bryant)

134. According to Ms. Sconyers, Respondent entered Patient A's room after she and Ms. Bryant had arrived there in response to the alarm sounding for Patient A's first pause. While circling Patient A's bed for several minutes, Respondent told Patient A to stay away from the white light and inquired whether Patient A had seen a white light. Respondent was gesturing with his hands and speaking loudly enough to be heard in the corridor, proclaiming that Patient A was going into "sudden death" and, therefore, her Cardizem infusion had to be discontinued. Although she was not certain, Ms. Sconyers believed that Ms. Brady asked Respondent to leave the room. (Testimony of Sconyers)

135. Ms. Sconyers reported Respondent's behavior to Ms. Sturge on January 11, 2006. (Testimony of Sconyers; Testimony of Sturge)

136. According to Respondent, he first went to Patient A's room when the alarm sounded for Patient A's fourth cardiac pause at some time between 4:00 and 4:30 a.m.[47] (Testimony of Respondent)

137. Respondent testified that having observed that Patient A was receiving 10 ml per hour of IV Cardizem, he returned to the nurses' station and explained that an overdose of Cardizem was causing Patient A's "... heart to stop, the pauses, the sinus arrests, asystole."[48](Testimony of Respondent; Exhibit 32)

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[47] Respondent testified that when the alarm sounded at the nurses' station, he asked which of his colleagues was assigned to Patient A. Someone, he thinks Ms. Brady, responded that "...she's been doing that all night." Declaring that Patient A needed checking, he went to Patient A's room to assess her. (Testimony of Respondent)

[48] Respondent claimed that neither Ms. Brady nor any other staff member on the Telemetry Unit had notified a physician or received a physician's order relative to Patient A despite her repeated pausing over a period of several hours before Respondent purportedly saw her at about 4:00 a.m. (Testimony of Respondent; Exhibits 27, 32)

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138. According to Respondent, he returned to Patient A's room with Ms. Brady, Ms. Bryant and, he believed, Ms. Sconyers. Ms. Brady refused his requests to turn off the Cardizem infusion, telling him that he was not the charge nurse. (Testimony of Respondent)

139. According to Respondent, he asked Patient A if she saw a white light in order to assess whether she was experiencing medication toxicity from an overdose of Cardizem, which he believed to be the cause of Patient A's pausing. Respondent described his inquiry whether Patient A had seen a white light as a "neuro/spiritual assessment". (Testimony of Respondent; Testimony of Sturge; Exhibits 27, 32)

140. According to Respondent, Patient A was awake and alert, but told him that she was lightheaded and having visual changes. (Testimony of Respondent)

141. Respondent testified that he and his colleagues returned to the nurses' station where he told them that Patient A was experiencing "sudden death".[49] Patient A would not have been able to hear his comment. (Testimony of Respondent)

142. In a written statement Respondent submitted to an investigator for the Board, Respondent asserted that while in the hallway, as he was getting the crash cart to bring to Patient A's room, he told his colleagues that Patient A was having "sudden cardiac death." (Exhibit 27)[50]

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[49] Respondent explained that he believed that Patient A was experiencing or going into "sudden death" because when the alarm sounded at about 4:00 a.m., it showed her ventricular heartbeat going to a flatline and the cardiac pauses were "precursors" of "sudden death". In a written statement submitted by Respondent to the Massachusetts Division of Health Care Quality ("DHCQ statement"), Respondent stated that Patient A was "seconds away" from asystole. Given the length of Patient A's pauses and his prior experience with cardiogenic shock, Respondent felt it was important to prevent such a result. (Respondent defined cardiogenic shock as system failure – the patient does not take in adequate oxygen, develops a glazed look, and becomes unresponsive). (Testimony of Respondent; Exhibit 2 – the DHCQ statement was attached to Respondent's Answer to the original Order to Show Cause and incorporated by reference in Respondent's Answer to the Amended Order to Show Cause. Additionally the DHCQ statement, being an attachment to Respondent's Answer, is a part of the administrative record in this proceeding.)

[50] In Respondent's written statement admitted as Exhibit 27, Respondent recounted that when the alarm sounded for Patient A at about 4:00 a.m., Ms. Brady stated, "Oh, she has been doing that all night"; that he ran down to Patient A's room and assessed her; that he "delegate[d]" to Ms. Brady to turn off the Cardizem drip; that he left Patient A's room to get the crash cart; and that while in the hallway, he told the other nurses that Patient A was experiencing "sudden cardiac death" and they

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143. According to Respondent, he moved the crash cart, with the defibrillator, to Patient A's room, hooked Patient A up to a portable monitor on the defibrillator, and did an EKG off the monitor. (Testimony of Respondent)

144. Respondent testified that when Ms. Marks arrived at the Telemetry Unit shortly thereafter, he informed her that Ms. Brady had refused to discontinue Patient A's Cardizem infusion, which continued to run at 10ml per hour, and that Patient A was in a "sudden death crisis," having experienced multiple "pauses" and "asystole". Ms. Marks refused to alter the Cardizem drip, stating "Wait until she becomes symptomatic."[51] (Testimony of Respondent)

145. According to Respondent, he was concerned about Patient A being alone without constant monitoring. Hence, he sat by Patient A's bed and held her hand as he watched the monitor. When an aide informed him that Ms. Brady wanted him to leave the room, Patient A asked him to stay. He was not permitted to turn off the Cardizem infusion. (Testimony of Respondent)

146. Respondent testified that he was still with Patient A when Dr. Qubti and Ms. Brady entered the room and Dr. Qubti ordered a halt to the Cardizem infusion.[52] Respondent further asserted that Dr. Qubti subsequently told him that Cardizem toxicity caused Patient A's cardiac pauses. (Testimony of Respondent)

147. According to Respondent, he, Ms. Brady, and a trainee transferred Patient A to the CCU.[53] (Testimony of Respondent)

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should get help. The statement goes on to read that Ms. Brady repeatedly refused to discontinue the Cardizem drip; that Respondent conducted a "neuro/spiritual assessment" of Patient A by asking her whether she saw a white light; and that Respondent stayed with Patient A until the doctor ordered that the Cardizem infusion be discontinued and Patient A transferred to the CCU. (Exhibit 27)

[51] In his DHCQ statement, Respondent alleged that Ms. Marks directed the Cardizem infusion be discontinued in the event of another pause. (Exhibit 2; administrative record of which the Board takes administrative notice).

[52] In the DHCQ statement, Respondent asserted that patient A's Cardizem infusion continued until her heart stopped. He also claimed that Patient A was unconscious, passed out in the bathroom. (Exhibit 2, administrative record of which the Board takes administrative notice)

[53] In the DHCQ statement, Respondent stated that Patient A was sent to the CCU and prepared for an emergency transfer to a Boston hospital for "extensive lifesaving care." (Exhibit 2; administrative record of which the Board takes administrative notice)

148. Other than comments he made in the presence of Ms. Bryant,[54] who was the charge nurse on the Telemetry Unit on the night in question, Respondent did not attempt to bring his concerns about Patient A's condition and the medication she was receiving to the attention of his superiors in the nursing chain of command or to a physician or other individual with authority to issue medication orders. (Testimony of Respondent; Exhibits 27, 32)

149. At no time on or before January 10-11, 2006 did Respondent review Patient A's medical record or obtain information about her medical history and background. Other than Cardizem and Ativan, he did not know and did not inquire which medications were prescribed for and taken by Patient A. (Testimony of Respondent)

Findings of Credibility

150. The Board credits the testimony of Dr. Covett, Dr. Kriegel, Ms. Marks and Ms. Sturge regarding the events at issue on the night of January 10-11, 2006. Each of these witnesses testified clearly and candidly, acknowledging that they were unable to answer certain questions posed by the parties because of failed memories or lack of knowledge about the subject matter.

151. The Board credits the testimony of Ms. Brady. Her testimony was clear, forthright, coherent, and reliable. It is abundantly apparent that on the night of January 10-11, 2006, she was intently focused on Patient A and carefully tracking the developing events concerning Patient A. Ms. Brady's truthfulness was enhanced by her willingness to readily acknowledge areas where her memory failed her and to admit that some of her memories regarding the details of Respondent's conduct were vague as she tried to remain focused on Patient A and her other patients rather than being distracted by Respondent's actions. While Ms. Brady testified that she did not rely on Respondent for advice on patient care because he appeared easily excitable, there is no evidence that Ms. Brady had any motive other

[54] Respondent did not specifically direct his comments to Ms. Bryant or have a conversation with her. Rather, Ms. Bryant just happened to be where she could hear Respondent's remarks about a white light and "sudden death". (Testimony of Bryant; Testimony of Respondent)

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than her concern for her patients to report Respondent's conduct to Ms. Sturge.

152. The Board finds that Ms. Bryant was a truthful and forthright witness.[55] She had a reliable memory of most of the salient events that occurred when Patient A experienced her first and second cardiac pauses. Ms. Bryant's strongest memories were of events that directly involved Patient A's care,[56] as opposed to more tangential details.[57]

153. Ms. Sconyers was direct, candid, and open in giving testimony. Her testimony corroborated much of Ms. Brady's and Ms. Bryant's testimony regarding Patient A's condition and care.[58] Like Ms. Bryant, Ms. Sconyers had certain lapses in memory. At times, she appeared confused over the precise sequence of events that she observed as she was involved with Patient A's care at several points during the night of January 10-11, 2006. Also like Ms. Bryant, Ms. Sconyers testified that she had a good working relationship with Respondent and there is no evidence to the contrary that would indicate bias against Respondent.

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55 Although given the opportunity, Respondent did not cross-examine Ms. Bryant at the hearing.

56 The reliability of much of Ms. Bryant's testimony is buttressed by its consistency with the testimonial evidence provided by Ms. Brady and Ms. Sconyers and with documentary evidence, including Ms. Brady's progress note for Patient A. Like Ms. Brady and Ms. Sconyers, Ms. Bryant stated that upon hearing the first alarm for Patient A sound at the nurses' station, she (Ms. Bryant) went to Patient A's room; that Ms. Brady assessed Patient A; that Patient A was alert and stable; and that Ms. Brady sought and received a physician's order for Patient A. With regard to the events surrounding Patient A's second pause, Ms. Bryant, like Ms. Brady, testified that Ms. Brady again called a physician about Patient A.

57 Ms. Bryant readily acknowledged her uncertainty and lack of memory of certain peripheral details (such as the precise time of the first pause and the exact whereabouts of colleagues). She explained that her main concern was that Patient A was stable; that she was focused on her own patients that night; and that her memory had faded over three years. It is clear from her testimony that after being assured that Patient A was alright and discussing Ms. Brady's consultations with physicians regarding Patient A, Ms. Bryant went back to her own duties and was primarily occupied with caring for the patients to whom she was assigned. (Testimony of Bryant)

58 As noted in Finding of Fact ¶100 and footnote 56, above, such testimony related to Ms. Sconyers and Ms. Bryant going to Patient A's room following the sounding of the first alarm, Ms. Sconyers and Ms. Brady assessing Patient A and finding her alert, conversant, and asymptomatic; Ms. Brady obtaining a physician's order regarding Patient A's Cardizem infusion; and Ms. Sconyers assisting Ms. Brady when she discontinued Patient A's Cardizem infusion by flushing the IV line. (Testimony of Brady; Testimony of Bryant; Testimony of Sconyers)

154. The Board is cognizant of the disparities in Ms. Brady's, Ms. Bryant's, and Ms. Sconyers' descriptions of the circumstances surrounding Respondent's white light inquiries of Patient A. That Ms. Bryant and Ms. Sconyers were not present with Ms. Brady at the nurses' station when Respondent reported Patient A saw a white light explains why Ms. Brady was the sole witness who testified to that incident. Moreover, as the nurse caring for Patient A, Ms. Brady closely monitored Patient A and was in and out of her room throughout the night. She would have had a heightened awareness of any activity in and around Patient A's room and would have been in a position to observe activity in the adjacent corridor that other nurses occupied with their own patients might not have noticed. As noted in Finding of Fact 151, above, Ms. Brady's testimony was entirely credible and reliable.[59] Moreover, Respondent did not deny asking Patient A about seeing a white light and commenting that Patient A was in danger of "sudden death", although he described the attendant circumstances differently.[60]

155. That notwithstanding, any explanation of the variations in the Bryant and Sconyers descriptions of Respondent asking Patient A about seeing a white light and making comments about "sudden death" would be based on conjecture and inferences that are too speculative to be reliable.[61] Hence, the Board reaches no conclusions as to the circumstances of Respondent's white light inquiry of Patient A other than to find in accordance with Ms. Brady's testimony, that at some point between Patient A's first and second pauses, Respondent asked Patient A whether she had seen a white light

[59] As noted in Finding of Fact ¶ 151, above, as the nurse assigned to Patient A, Ms. Brady was intently focused on Patient A and carefully tracking the evolving situation. (Testimony of Brady)

[60] As noted above, in the written statements he presented to the Board and in his testimony before the Board, Respondent presented different accounts of the circumstances surrounding his remarks about "sudden death".

[61] For example, the record leaves open the possibility that Ms. Brady had left Patient A's room to view the monitor at the nurses' station when Respondent inquired about the white light and commented, in Patient A's room, on "sudden death"; or that because Respondent asked the white light question and spoke about sudden death multiple times, Ms. Bryant and Ms. Sconyers, who had their own patients and may not have always been in Patient A's room at the same moment, heard the remarks at different times; or that Ms. Brady and Ms. Sconyers were so focused on assessing Patient A and ensuring her stability that neither noticed Respondent making the comments in the doorway that Ms. Bryant described. It is clear that the events concerning Patient A happened quickly and that Ms. Brady and her two colleagues were first and foremost focused on ensuring Patient A's wellbeing.

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and reported the incident to Ms. Brady at the nurses' station. Likewise, the Board reaches no conclusions about Respondent's pronouncements about "sudden death" inside Patient A's room. On the basis of Ms. Brady's testimony, we find only that while pacing the hallway abutting Patient A's room, Respondent repeatedly uttered in a loud and audible voice that Patient A was in danger of "sudden death".

156. The Board finds that Respondent's testimony was disingenuous, self-serving, inconsistent with other testimonial and documentary evidence, and unreliable. The Board does not credit Respondent's narrative of the events involving Patient A that purportedly occurred at or about 4:00 a.m., including the circumstances surrounding Respondent's white light inquiry and remarks about "sudden death".[62]

157. The Board rejects Respondent's assertion that he first learned about Patient A's pauses when the alarm sounded for her fourth pause. Respondent's testimony is contrary to other testimonial evidence that the Board has credited. Moreover, it is inconceivable that on a floor of just over 20 patients, Respondent would have been unaware of the activity related to Patient A's pauses that took place over a period of several hours. Multiple alarms had sounded at the nurses' station; Ms. Brady reviewed and printed out Patient A's monitor readings at the nurses' station; at various times, three (3) of Respondent's colleagues were involved with Patient A's care and both Ms. Marks and Dr. Qubti were on the floor to assess Patient A.

158. The Board also rejects Respondent's implausible assertion that Patient A was still receiving Cardizem (10 ml per hour) when she experienced her fourth cardiac pause between 4:00 and 4:30 a.m. Such testimony is at odds with Ms. Brady's Progress Notes and the testimony of each of the other nurses who was present on the floor and involved with Patient A that evening. Moreover, the testimony is inconsistent with Dr. Covett's testimony that he ordered Patient A's Cardizem infusion to be decreased to 5 ml per

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[62] The Board does, however, find that Respondent participated in transferring Patient A to the CCU, as described by Ms. Brady. (Testimony of Brady; Testimony of Respondent)

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hour and to be discontinued with further pausing and that he gave the order sometime between 11:00 p.m. and 12:00 a.m.

159. Respondent's assertion that no physician saw Patient A or was consulted about Patient A before Dr. Qubti assessed Patient A after 4:00 a.m. strains credulity. It flies in the face of both Dr. Covett's and Dr. Kriegel's testimony that they were called about Patient A after her first and second pauses respectively. Additionally, it is inconsistent with the testimony of Ms. Brady and the colleagues who assisted with Patient A, as well as with Ms. Brady's documentation in Patient A's medical record. (Testimony of Respondent; Exhibits 27 and 32)

160. Also incredible is Respondent's testimony that after assessing Patient A at about 4:00 a.m., Dr. Qubti ordered the cessation of the Cardizem infusion and told Respondent that Patient A was experiencing Cardizem toxicity. There is no documentation anywhere in the record showing Dr. Qubti ordering the cessation of Patient A's Cardizem drip after 4:00 a.m. Moreover, if Dr. Qubti initially assessed Patient A after her third pause, shortly after 2:00 a.m., as the Board has found he did, and if Dr. Qubti was concerned about Cardizem toxicity, he would in all likelihood have given an order related to Patient A's Cardizem infusion had it still been running at that time.

161. Respondent's assertion that at the time of Patient A's fourth pause, Ms. Brady stated "She's been doing that all night" and failed to respond to the alarm is likewise inconceivable. It is inconsistent with the attentive care Ms. Brady had given Patient A up to that point and assumes that Ms. Brady completely neglected and ignored her responsibility to promptly respond to an alarm. Equally implausible is Respondent's testimony that Ms. Brady flatly refused his pleas to discontinue Patient A's Cardizem drip after the fourth pause. Such testimony presumes that that despite Patient A's multiple pauses over a number of hours, both Ms. Brady and her colleagues, who allegedly were also in Patient A's room when Respondent made his plea, were content to continue the medication regimen prescribed

for Patient A hours earlier, upon her transfer from the ED to the Telemetry Unit, without even seeking consultation with a physician.[63]

162. Additionally, the Board finds it utterly inconceivable that Ms. Marks would have told Respondent that she would not alter Patient A's Cardizem drip until Patient A became symptomatic or had another pause. Despite her status as a Night Nursing Supervisor, Ms. Marks would have had no authority over Patient A's medication absent a physician's order. Moreover, accepting that Ms. Marks would have been so cavalier would be at odds with Ms. Marks' testimony[64] and premised on believing that Ms. Marks would have made such an irresponsible remark about a patient who had experienced four relatively lengthy cardiac pauses.

163. The Board finds that Patient A required medication for anxiety over and above her scheduled medication. However, the evidence was insufficient and too speculative to establish that Respondent's behavior caused or even contributed to Patient A's additional anxiety and resulted in Patient A needing extra doses of Ativan. (Testimony of Brady; Testimony of Bryant; Testimony of Sconyers; Testimony of Respondent)

164. Following the incidents on the night of January 10 -11, 2006, Brockton Hospital terminated Respondent's employment.[65] (Testimony of Sturge; Testimony of Respondent; Exhibits 17)

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[63] In the DHCQ statement, Respondent recounted Ms. Bryant stating that she told Ms. Brady to call a physician about Patient A throughout the night, but Ms. Brady refused. Such a statement, like Respondent's testimony and other written statements on the issue, was incompatible with Ms. Bryant's testimony as well as with the testimony of multiple other witnesses. Moreover, Respondent never examined Ms. Bryant about her purported statement. (Testimony of Brady; Testimony of Bryant; Testimony of Covett; Testimony of Kriegel; Testimony of Sconyers; Testimony of Respondent; Exhibits 2, 27, 32; administrative record of which the Board takes administrative notice)

[64] In cross examining Ms. Marks, Respondent failed to inquire about Ms. Marks' purported refusal to do anything about Patient A's alleged situation until she became symptomatic or experienced another pause. (Testimony of Marks)

[65] On January 11, 2006, Ms. Sturge and Respondent spoke by telephone. Ms. Sturge stated that she "... could not do this anymore." She informed Respondent that she would not be able to schedule him for additional shifts as a result of the "white light" and "sudden death" incidents as well as concerns that had arisen earlier regarding Respondent's conduct. (These issues, which are not the subject of this proceeding, included Respondent taking excessive smoking breaks and provoking confrontations with hospital colleagues, particularly ED physicians and staff who were transferring patients to the Telemetry Unit). (Testimony of Sturge)

165. In late January or early February 2006, Respondent sent a letter with attached photographs to the hospital's CEO and Director of Human Resources ("HR"), Mr. Avila. The letter, in which Respondent asked for his job back, contains allegations that the Administrative Coordinator ("AC") on the 3:00 p.m. to 11:00 p.m. shift[66] had set Respondent up to be fired over a request for time off and had sexually harassed him and other employees over whom she had supervisory authority.[67] The letter describes the AC as "the little tramp", "a gutter whore", a "dominatrix", and "the hospital whore" and contains explicit descriptions of sexual conduct in which the AC purportedly engaged. (Testimony of Sturge; Testimony of Walsh; Exhibit 17)[68]

166. In response to Respondent's letter, on or about February 6, 2006, Ms. Walsh convened a meeting to commence an investigation of Respondent's claims. In addition to Respondent and Ms. Walsh, Mr. Avila and an attorney for the hospital attended the meeting. At the meeting, Respondent was unable to focus on the conversation, skipped from one topic to the next ... from calling the AC a "tramp and whore" who sexually harassed him and other subordinate employees, to describing in graphic sexual terms a photograph of the AC at the nurses' station, to stating that he was fired for asking a lady about a white light as a standard neurological assessment. (Testimony of Walsh)

Respondent acknowledged to Ms. Sturge that on the previous evening, he had asked Patient A about seeing a white light, acted inappropriately, and interfered with Ms. Brady's care of Patient A. (Testimony of Sturge)

66 Ms. Marks, who worked the night shift, was not the Administrative Coordinator who was the subject of Respondent's letter. (Testimony of Walsh)

67 Respondent's letter also stated, "I got fired for assessing a patient for Cardizem toxicity per debra sturge." (Exhibit 17) (The Board notes that issues pertaining to the validity or invalidity of Respondent's claims are not part of these proceedings. The Board has no jurisdiction to adjudicate claims of sexual harassment and Respondent has addressed these claims in the appropriate forums).

68 According to Ms. Walsh, photographs were attached to Respondent's letter. The photographs were not offered into evidence and do not constitute a part of the record of these proceedings before the Board. (Testimony of Walsh; Exhibit 17)

167. Following an investigation, the hospital found that Respondent's claims of sexual harassment were unfounded.[69] In a letter to Lois M. Marshall, an investigator with the Division of Health Professions Licensure's Office of Public Protection, Ms. Walsh stated that in the course of the investigation, the hospital discovered that Respondent "...had engaged in multiple instances of highly inappropriate conduct." Ms. Walsh testified that the behavior she referenced included sexually inappropriate conduct and in her letter, expressed concern about Respondent's "judgment and assessment of reality". (Testimony of Walsh; Exhibit 17)

Violations of Accepted Standards of Nursing Practice

168. In accordance with the testimony of Ms. Snydeman, the Board finds that Respondent violated accepted standards of nursing practice by inquiring of Patient A whether she had seen a white light. Such a question did not constitute part of a neurological or other proper nursing assessment, and could only have been asked if Patient A had raised the issue with Respondent. (Testimony of Snydeman)

169. In accordance with the testimony of Ms. Snydeman, the Board finds that Respondent violated accepted standards of nursing practice by pacing the hospital corridor abutting Patient A's room and loudly proclaiming within earshot of Patient A that Patient A was experiencing or going into "sudden death" because of her continuing Cardizem infusion. (Testimony of Snydeman)

170. In accordance with the testimony of Ms. Snydeman, the Board finds that in asking Patient A whether she had seen a white light and in loudly proclaiming in the corridor outside Patient A's room that Patient A was going into "sudden death", Respondent failed to create a comforting and therapeutic environment for Patient A. To the contrary, Respondent

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[69] Based on the investigation, Ms. Walsh concluded that Respondent was terminated from Brockton Hospital for inappropriate behavior with Patient A, including asking her whether she saw a white light, and for a few other problems with his performance, including, but not limited to, the nature of Respondent's interactions with ED staff and excessive smoking breaks. (Testimony of Walsh; Exhibit 17)

behaved in a manner that was likely to induce or increase anxiety in a patient. As such, Respondent's conduct failed to comply with accepted standards of nursing practice. (Testimony of Snydeman)

171. In accordance with the testimony of Ms. Snydeman, the Board finds that in channeling his concerns about Patient A's status into an inquiry whether Patient A had seen a white light and loud proclamations about "sudden death" and the need to discontinue Patient A's Cardizem infusion, Respondent failed to comport with accepted standards of nursing practice that require a nurse with such concerns to address them through the nursing chain of command and, if necessary, address them with a physician. (Testimony of Snydeman)

172. In accordance with the testimony of Ms. Snydeman, the Board finds that in asking Patient A whether she had seen a white light and making loud pronouncements about Patient A going into "sudden death" if her Cardizem infusion continued, Respondent inappropriately interfered with Ms. Brady's care of Patient A and failed to comport with accepted standards of nursing practice that require nurses to act in a respectful, collaborative, and professional manner with their colleagues. (Testimony of Snydeman)

173. In accordance with the testimony of Ms. Snydeman, the Board finds that Respondent violated accepted standards of nursing practice by submitting to Brockton Hospital's CEO and Director of HR a letter that referred to Respondent's nursing colleague's sexual preferences and habits and described said colleague as a "dominatrix", "gutter whore", "hospital whore" and "little tramp". (Testimony of Snydeman)

Findings Relative to Sanction

174. A performance evaluation written by Ms. Sturge in September 2005 (four [4] months before the events in question), states that Respondent "...demonstrates the clinical skills and critical thinking needed to maintain a high standard of care" and "... enjoys sharing his knowledge as a preceptor and a patient educator." The performance evaluation also noted that

Respondent was "...working on his interpersonal skills to promote a positive work environment." (Testimony of Sturge; Exhibit 13)

175. A resume Respondent submitted to the Board contains a large of amount of information about Respondent's personal life and unusual descriptions of his work experiences. It recounts in detail the death of a patient (not assigned to Respondent) and Respondent's role with the patient and the family, including asking the family to join hands with him around the bedside and leading them in prayer. The resume reflects a lack of understanding of professional relationships and communications between nurses and their professional counterparts and a failure to comprehend the boundaries of a nurse's professional role. (Exhibit 31)

IV. Rulings of Law

1. Based upon Finding of Fact ¶ 1, above, the Board has jurisdiction to hear this disciplinary matter involving Respondent Michael J. McAndrews, RN License No. 239918.
2. Respondent's conduct in asking Patient A whether she had seen a white light, as set forth in Findings of Fact ¶¶ 126, 127, 131, 150, 151, 155, 169, 171, and 172, above, constitutes malpractice pursuant to G.L. c. 112, §61.
3. Respondent's conduct in asking Patient A whether she had seen a white light, as set forth in Findings of Fact ¶¶ 126, 127, 131, 150, 151, 155, 169, 171, and 172, above, violates 244 CMR 9.03 (5), (15), (17), and (47), constituting grounds for discipline pursuant to 244 CMR. 9.03 and G.L. c. 112, §61.
4. Respondent's conduct in pacing through the corridor abutting Patient A's room and loudly proclaiming that Patient A was going into "sudden death" from an infusion of Cardizem that needed to be discontinued, as set forth in Findings of Fact ¶¶ 126, 129, 131, 150, 151, 155, 170 – 172, above, constituted malpractice pursuant to G.L. c. 112, §61.

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5. Respondent's conduct in pacing through the corridor abutting Patient A's room and loudly proclaiming that Patient A was going into "sudden death" from an infusion of Cardizem that needed to be discontinued, as set forth in Findings of Fact ¶¶ 126, 129, 131, 150, 151, 155, 170 – 172, above, violates 244 CMR 9.03 (5), (15), (17), and (47) and constitutes grounds for discipline pursuant to 244 CMR 9.03 and G.L. c. 112, §61.
6. Respondent's conduct in asking Patient A whether she had seen a white light and in pacing the corridor making loud comments about sudden death and the need to discontinue Patient A's Cardizem infusion, as set forth in Findings of Fact ¶¶ 126, 127, 129, 131, 150, 151, 155, 169, 170, 171, and 172, above, constitutes unprofessional conduct and undermines public confidence in the integrity of the nursing profession, constituting grounds for discipline of Respondent's nursing license.
7. Respondent's conduct in submitting to Brockton Hospital's CEO and Director of HR a letter in which Respondent described a nursing colleague in sexually derogatory and demeaning terms and referred to the colleague's sexual preferences and habits, as set forth in Findings of Fact ¶¶ 165-167 and 173, above, violates 244 CMR 9.03 (5) and constitutes unprofessional conduct that undermines public confidence in the integrity of the nursing profession. *Raymond v. Board of Registration in Medicine*, 387 Mass. 708, 713; *Sugarman v. Board of Registration in Medicine*, 422 Mass. 338, 342-343 (1996)

DISCUSSION

Pursuant to G.L. C. 112, sec. 61 the Board has authority to discipline nurses for engaging in deceit, malpractice, gross misconduct in the practice of the nursing profession, or for any offense against the laws of the Commonwealth related thereto. Chapter 112, § 61 reads in pertinent part:

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[E]ach Board of Registration...may...suspend, revoke, or cancel any certificate, registration, license or authority...if it appears... that the holder of such certificate, registration, license, or authority,... is guilty of deceit, malpractice, gross misconduct in the conduct of the profession, or any offense against the laws of the commonwealth relating thereto...

The Board's regulations at 244 CMR 9.03 require all nurses licensed by the Board and engaged in the practice of nursing to know and understand the Standards of Conduct set forth at 244 CMR 9:00, all state laws and regulations governing the practice of nursing, and all other state and federal laws and regulations related to the practice of nursing. Under the regulation, the Board may discipline licensees for failure to comply with the Standards of Conduct for Nurses or with any other laws and regulations related to the practice of nursing.

Consistent with its mandate to promote the public health, safety and welfare, the Board also has authority to discipline nurses for unprofessional conduct and conduct undermining public confidence in the integrity of the profession. *Kvitka v. Board of Registration in Medicine*, 407 Mass. 140, cert. denied, 498 U.S. 823 (1990) ("The board has the authority to protect the image of the profession."); *Raymond v. Board of Registration in Medicine*, 387 Mass. 708, 713 (1982); *Reed v. Board of Registration of Psychologists*, Suffolk Superior Court, No. 96-5242-B, August 19, 1997 (Memorandum of Decision and Order) at p. 15 (board has authority to sanction licensee for conduct which it finds to be unprofessional or unethical); *aff'd*, *Reed v. Board of Registration of Psychologists*, Massachusetts Court of Appeals, No. 97-P-2137, April 12, 1999, citing *Sugarman v. Board of Registration in Medicine*, 422 Mass. 338, 342 (1996) ("the board has broad authority to regulate the conduct of the...profession, ...[which] includes its ability to sanction [professionals] for conduct which undermines public confidence in the integrity of the...profession.")

Respondent's conduct on the night of January 10 – 11, 2006 and Respondent's letter to Brockton Hospital's CEO and Director of HR, reflect an inability to recognize and abide by the boundaries and accepted practices of the nursing profession, to exercise sound nursing judgment, to maintain a professional demeanor,

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and to work respectfully and collegially with other nurses and health care professionals.

As Ms. Snydeman testified, accepted standards of nursing practice require nurses to create therapeutic, comforting patient environments and to relate to one another respectfully, collaboratively, and professionally. Acting in such a manner, a nurse ("second nurse") with concerns about medication being administered to another nurse's ("primary nurse") patient should initially request more information about the patient from the primary nurse. The second nurse should seek a clear understanding of the patient's history, background, condition, and plan of care so that he has a proper context for evaluating his concerns. If the second nurse continues to have concerns after obtaining information about the patient and conferring with the primary nurse, he should pursue his concerns through the hospital's nursing chain of command. Generally, that entails speaking with the charge nurse on the floor, and, if necessary, with nursing supervisors/managers, whether on or off the premises. In the event that this process proves unsatisfactory, the second nurse may contact a physician.

Consistent with Ms. Snydeman's testimony, pursuant to accepted standards of nursing practice, a nurse may not diagnose patients and discuss such a diagnosis with patients or colleagues. Nor does a nurse possess the authority to order medication, change a physician's medication order, or order another nurse to give a medication or change a physician's medication order. Hence, a second nurse with concerns about a patient's medication regimen, may not render his own diagnosis of the patient, discuss that diagnosis with the patient or colleagues, or direct another nurse to change a duly given medication order on the basis of his diagnosis.

Moreover, while a nurse on a Telemetry Unit should check on a patient if the patient's alarm sounds, that nurse should not interfere with the primary nurse's care of the patient unless the primary nurse is unavailable or seeks assistance. In instances of cardiac pausing, an experienced second nurse may advise a less experienced primary nurse who is not able to properly assess and manage the situation. Under no circumstances may such advice include diagnoses and medication orders.

The testimony of Ms. Brady, Ms. Bryant, Ms. Sconyers, Ms. Marks, Dr. Covett, and Dr. Kriegel, as well as Patient A's medical record for the night of January 10–11, 2006, establish that Ms. Brady provided appropriate care to Patient A and consulted and collaborated with her nursing colleagues in caring for Patient A. Ms. Marks was notified of Patient A's condition and involved with her care. Ms. Brady had telephone consultations with Dr. Covett, who was covering for Patient A's primary care physician, and with Dr. Kriegel, the cardiologist overseeing Patient A's care. Additionally, she summoned the CCU resident to examine Patient A on two occasions. Despite Respondent's protestations to the contrary, Ms. Brady followed doctors' orders, rendered care that kept Patient A stable, and advocated with Dr. Qubti for Patient A's transfer to the CCU. According to Dr. Kriegel and/or Ms. Marks, Patient A had a serious and concerning condition; however, she remained stable, was not allergic to Cardizem, did not receive an overdose of Cardizem, and did not experience a heart attack, cardiac arrest/asystole, or death.[70]

In asking Patient A whether she had seen a white light, Respondent interfered with Ms. Brady's care of Patient A.[71] As Ms. Brady testified, Respondent inserted himself into a situation that was under control. Moreover, while Respondent contended he was conducting a neuroassessment of Patient A, Ms. Snyderman's testimony establishes that asking a patient whether she has seen a white light does not constitute a neurological or any other type of accepted nursing assessment and that such a question is never appropriate or within accepted standards of nursing practice, unless the patient raises the issue with the nurse first.

Exacerbating Respondent's use of an inappropriate means of "assessment" is the fact that his particular question – inquiring whether a patient saw a white light – has the clear potential to evoke or heighten anxiety in the patient. Such conduct

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[70] As set forth in Findings of Fact, ¶ 118, above, Dr. Kriegel diagnosed Patient A with Tachy-Brady Syndrome and atrial fibrillation within about a week of her hospitalization on January 10-11, 2006. Dr. Kriegel noted that with Patient A's underlying condition, absent a pace maker, any drug administered to slow the heart rate could have contributed to cardiac pausing. Hence, discontinuing Patient A's Cardizem in accordance with Dr. Covett's order, was the appropriate step to take when Patient A had cardiac pauses.

[71] While the Board concluded that the evidence was insufficient to make a finding as to the particular circumstances surrounding Respondent's white light inquiry, the Board found that at some point between Patient A's first and second pauses, Respondent asked Patient A whether she had seen a white light and subsequently conveyed to Ms. Brady that Patient A had reported seeing a white light.

stands in direct contrast to a nurse's duty to create a comforting and therapeutic environment for a patient, particularly an alert and aware cardiac patient like Patient A.

Respondent compounded his failure to create a comforting, therapeutic environment for Patient A by ranting about Patient A going into "sudden death" while pacing the corridor abutting Patient A's room. Speaking loudly, Respondent's comments were made within earshot of Patient A.[72] Such comments are highly likely to evoke or heighten anxiety in a patient and are of even greater concern when the patient has a significant cardiac condition. Additionally, such conduct is disturbing and distracting to other nurses and health care professionals in the vicinity. A hyper nurse who repeatedly calls out that a patient is experiencing sudden death and acts in a dramatic and agitated manner because he cannot keep his fears about the patient in check, creates a scene that is thoroughly antithetical to the calm, therapeutic environment contemplated by accepted standards of nursing practice.

If Respondent had real concerns about Patient A's care, there were well established means by which he could have addressed such issues in a constructive and professional way. Initially, Respondent should have approached Ms. Brady in a courteous and collaborative manner to obtain additional information about Patient A and express his concerns. If still dissatisfied and apprehensive, Respondent should have pursued the nursing chain of command with Ms. Bryant, the charge nurse,[73] and, if necessary, with Ms. Marks and her superiors, even if they were off site. As a final measure, Respondent could have contacted a physician.[74] Respondent did none of these things. Rather, on the basis of extremely limited knowledge, Respondent jumped to inaccurate diagnostic conclusions, presumed he knew the cause of Patient

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[72] The Board made no findings as to whether or not Respondent made comments about Patient A experiencing "sudden death" inside Patient A's room. As noted in Finding of Fact, ¶ 155, above, given the disparities in Ms. Bryant's and Ms. Sconyers' descriptions of Respondent's utterances of "sudden death", any such findings would have been based on conjecture and inferences that would have been too speculative to be considered reliable evidence.

[73] Although Respondent may have made remarks that Ms. Bryant overheard in the background, they were not the sort of communication that constitutes a professional, collaborative, and beneficial exchange between colleagues.

[74] Respondent knew or should have known that nursing staff were not authorized to change or discontinue Patient A's Cardizem infusion absent a physician's order. Such an order, if appropriate, could have been obtained by Patient A's primary nurse (who in fact did obtain an order from Dr. Covett) or any other nurse within the nursing chain of command on the night in question. Ranting that Patient A's Cardizem needed to be discontinued was not an appropriate way to advocate for a change in a patient's medication regimen.

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A's cardiac pauses, and acted out in a manner that was utterly unprofessional, uncontrolled, and in violation of accepted standards of nursing practice.

Rather than channeling his concerns in a constructive way, Respondent exhibited the type of behavior that neither benefits colleagues nor promotes positive patient outcomes. As noted, such behavior may exacerbate patient anxiety. Moreover, it is extremely disruptive for the primary nurse and colleagues who may be assisting her. Ms. Brady testified about her efforts to avoid being distracted by Respondent's conduct and to maintain her focus on Patient A and her other patients. Despite those efforts, Ms. Brady was upset by Respondent's behavior and further dismayed when he implied that Patient A might die, like a former patient of his who reportedly saw a white light before passing away.

Respondent's conduct in asking Patient A whether she had seen a white light was unprofessional, violated accepted standards of nursing practice, constituted malpractice, and failed to safeguard Patient A's dignity. Likewise, in loudly proclaiming that Patient A was going into "sudden death" in the corridor abutting Patient A's room, Respondent behaved unprofessionally, violated accepted standards of nursing practice, committed malpractice, and compromised Patient A's privacy and dignity. Whether or not Respondent's behavior actually caused Patient A harm by increasing her anxiety, it had great potential to do so. Certainly, by upsetting and distracting nurses caring for Patient A with his disruptive behavior and by failing to maintain Patient A's privacy and dignity, Respondent acted in a manner that was harmful to Patient A. As such, Respondent's conduct violated G.L. c. 112, § 61, 244 CMR 9.03 (5), (15), (17), and (47).

Respondent's testimony was unpersuasive, implausible, self-serving, and at times inconsistent. As Prosecuting Counsel asserted in his Brief, Respondent attempted to shift the focus of the Board's attention from his conduct to the purported failures of other staff at Brockton Hospital to care for Patient A in a safe and competent manner. However, in his Brief, Respondent acknowledged that there was no wrongdoing on the part of anyone at Brockton Hospital; that Patient A was properly monitored by the nursing staff; that Patient A's care was appropriately

overseen by physicians who were contacted by nurses caring for Patient A; and that Patient A received the "best of care".[75]

In defense of his conduct, Respondent sought to portray an urgent situation in which Patient A was in imminent danger of death; he was the sole nurse cognizant of that danger and qualified to properly care for Patient A; and he was the sole nurse responding to Patient A's medical needs while others neglected Patient A or acted utterly irresponsibly. Respondent's depiction of the events was not credible.

While contending that at or about 4:00 a.m., Patient A was still receiving 10 ml per hour of Cardizem, Respondent also attempted to demonstrate that a "Hep Lock" order given in the ED precluded Patient A from receiving Cardizem on the night in question. Hence, Respondent took inconsistent and irreconcilable positions, i.e. that Patient A never received Cardizem and that Patient A suffered an overdose of Cardizem. Neither position was supported by the evidence.

The evidence overwhelmingly contradicted Respondent's assertions that he first saw Patient A at or about 4:00 a.m.; that Patient A's Cardizem was still running at 10 ml per hour; that no physician had been involved with Patient A's care from the onset of her cardiac pauses and that Ms. Brady and Ms. Marks refused and/or neglected to contact a physician or take any appropriate measures to deal with Patient A's pausing; and that it was about 4:00 a.m. when he asked Patient A whether she had seen a white light.

With the commotion of alarms sounding and various nurses and physicians being involved with Patient A's care, it is unfathomable that Respondent would have been present on the Telemetry Unit and unaware of Patient A over a period of 4-5 hours. Additionally, the testimony of various witnesses, including Ms. Brady, Ms. Sconyers, Dr. Covett, and Dr. Kriegel, as well as Patient A's medical record, demonstrate that Ms. Brady received and executed an order from Dr. Covett after Patient A's initial pause that called for her to decrease by half Patient A's Cardizem

[75] In his Brief, Respondent asserts that Attorney Kowal misled him in preparing and presenting his defense, with the result being that Respondent believed there was wrongdoing on the part of his colleagues. Once he became aware that Attorney Kowal provided an incorrect legal analysis of the case, he realized that no such wrongdoing occurred. (For the record, the Board notes that throughout the course of the hearings, Respondent did not alter his defense, even after Attorney Kowal withdrew from the case). Asserting that neither he nor his colleagues did anything wrong in caring for Patient A, Respondent asks that the Board dismiss all charges against him.

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infusion and to discontinue the medication with further pausing.[76] Patient A's Cardizem was discontinued at approximately 1:00 a.m., three (3) hours before Respondent claimed he observed the medication flowing at 10 ml per hour.

Respondent's description of Ms. Brady's and Ms. Marks' refusal to contact or summon a physician about Patient A's pausing and Cardizem infusion is inconceivable and patently inconsistent with Respondent's Brief. The testimony of one witness after another showed that Ms. Brady could not have been more diligent in contacting the appropriate physicians throughout the night to notify them of Patient A's condition and to obtain orders to appropriately care for Patient A. In addition to the testimony of Ms. Brady and her nursing colleagues, both Dr. Covett and Dr. Kriegel affirmed Ms. Brady's consultations with them. Moreover, testimonial and documentary evidence substantiate Dr. Qubti's two assessments of Patient A at the hospital.

Hence, the credible evidence is at complete odds with Respondent's claim that he asked Patient A about seeing a white light when he first encountered her at or about 4:00 a.m. and saw her Cardizem infusion still running. Ms. Brady's testimony establishes that Respondent made his inquiry of Patient A between her first and second pause. Moreover, as Ms. Snydeman testified, accepted standards of nursing practice prohibit a nurse from making such an inquiry at any time, unless the patient has raised the issue first. In accordance with Ms. Snydeman's testimony, asking a patient about seeing a white light does not constitute an accepted nursing assessment of any kind. To the contrary, the question may evoke or heighten anxiety in a patient in contravention of a nurse's duty to create a comforting, secure, therapeutic patient environment.

Likewise, Respondent did not express his concern about Patient A experiencing "sudden death" in the calm and discreet manner that he described as preserving a comforting and therapeutic environment for Patient A. Although Respondent contended that at about 4:00 a.m., he told his nursing colleagues at the nurses' station that Patient A was experiencing "sudden death", not a single one of

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[76] Although Ms. Brady's failures to document two orders (Dr. Covett's order regarding Patient A's Cardizem infusion and a subsequent order to administer Ativan to Patient A) on the Physician's Order Form are not the subject of this proceeding, the Board takes note of its concern about the inadequacy of the documentation.

Ativan ordered by Dr. Cof.

Respondent's colleagues testified to such a scenario or was asked about it on cross examination. Rather, the credible and reliable evidence before the Board establishes that Respondent started to "rant" about Patient A going into "sudden death" when he learned that pursuant to Dr. Covett's order, Patient A was continuing to receive Cardizem at 5 ml per hour. Respondent persisted with his proclamations of "sudden death" in a loud voice that would have been audible to Patient A. Like the white light question, Respondent's utterances of "sudden death" could have heightened Patient A's anxiety and were the antithesis of creating a comforting, secure, and therapeutic environment.

In summary, regardless of whether there were exigent circumstances as Respondent contended, Respondent's conduct on the night of January 10-11, 2006 would have violated accepted standards of nursing practice, constituted malpractice, demonstrated poor nursing judgment, and an inability to maintain a professional demeanor. Failing to utilize the nursing chain of command to express his concerns about Patient A's care, Respondent instead acted in a manner that was potentially distressing and frightening to a patient with a cardiac condition and that was upsetting and distracting to his colleagues, particularly the nurse responsible for Patient A's care. Respondent's attempt to defend his conduct by representing an emergent situation in which he was the sole responsible actor was not substantiated by the evidence and would not have justified Respondent's behavior even if proven. Moreover, Respondent exhibited a failure to accept any responsibility for his highly inappropriate behavior. Although in his Brief Respondent belatedly acknowledged that Patient A received good and appropriate care throughout the night in question, Respondent continued to deny that he engaged in misconduct, asking the Board to dismiss all charges against him.

The letter Respondent submitted to Brockton Hospital's CEO and Director of HR was thoroughly unbusinesslike[77] and is further evidence that Respondent lacks

[77] Respondent behaved in a similarly inappropriate manner at the meeting convened by hospital administrators to investigate the claims of sexual harassment in Respondent's letter. Ms. Walsh recounted some of the graphic and sexually explicit language that Respondent used in reference to the nurse he had described as a "dominatrix" and "whore".

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the capacity to conduct himself in a professional way, to exercise self-control and follow customary processes for directing one's concerns and grievances, and to conform to accepted standards of nursing practice. Respondent's derogatory accusations about his nursing colleague and his repeated usage of indelicate language were highly inappropriate for such a communication and violated accepted standards of nursing practice. As Ms. Snyderman testified, accepted standards of nursing practice require nurses to act collegially, respectfully, and professionally when interacting with one another or speaking to one colleague about another colleague. Hence, references to a colleague's sexual habits and preferences and the use of disparaging expressions such as "the little tramp," "gutter whore", "hospital whore", and "dominatrix" to describe a colleague to hospital administrators is incompatible with accepted standards of nursing practice.

Moreover, the resume Respondent submitted to the Board reflects in a different way Respondent's lack of understanding for professional boundaries and for what constitutes appropriate communication. The resume describes conduct that falls outside the usual course of nursing practice with a dying patient (to whom Respondent was not assigned) and makes reference to personal factors in Respondent's life that have no place in a professional resume.

The evidence before the Board demonstrates a pattern of troubling behavior that raises grave concerns about Respondent's capacity to exercise good nursing judgment and practice nursing in a professional manner that comports with accepted standards of nursing care and promotes safe and positive outcomes for patients. Respondent has given no hint that he recognizes or accepts responsibility for his misconduct. While Respondent's Brief indicates that he no longer blames the acts of others for his behavior, he continues to defend the propriety of his behavior. Respondent's behavior with regard to Patient A, the letter he submitted to Brockton Hospital's administrators, and his ongoing failure to acknowledge his misconduct reflect poorly on the nursing profession and undermine public confidence in the integrity of the profession.

Accordingly, the Board concludes that Respondent's conduct is subject to discipline and orders as follows:

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ORDER

Based on its Final Decision and Order, the Board SUSPENDS the Respondent's right to renew his license to practice as a REGISTERED NURSE in Massachusetts, RN License No. 239918 for an indefinite period. . .

Respondent shall not practice as a Registered Nurse in Massachusetts on or after the Effective Date of this Order. "Practice as a Registered Nurse" includes, but is not limited to, seeking and accepting a paid or voluntary position as a Registered Nurse or in any way representing himself as a Registered Nurse in Massachusetts. The Board shall refer any evidence of unlicensed practice to appropriate law enforcement authorities for prosecution as provided by G.L. c. 112, §§ 65 and 80.

If Respondent renews his license to practice as a Registered Nurse in Massachusetts before the Effective Date of this Final Decision and Order, the Board SUSPENDS said LICENSE, RN License No. 239918.

Suspension Termination Respondent may petition the Board in writing for termination of his license suspension ("suspension termination") at such time as he is able to provide documentation satisfactory to the Board that demonstrates his ability to practice nursing in a safe and competent manner. This documentation shall include but shall not be limited to the following:

1. A comprehensive mental health evaluation of the Respondent conducted by a licensed mental health provider which meets the requirements set forth in Attachment B 2;

2. certified Court and/or Agency documentation that there are no pending actions or obligations, criminal or administrative, against the Respondent before any court or Administrative Agency including, but not limited to:

   a. Documentation that *at least one (1) year prior to any petition for reinstatement* the Respondent satisfactorily completed all court requirements (including probation) imposed on her/him in connection with any criminal matter and a description of those completed requirements and/or the disposition of such matters;[78]

   b. Certified documentation from the state board of nursing of each jurisdiction in which the Respondent has ever been licensed to practice as a nurse, sent directly to the Massachusetts Board identifying his license

[78] The Respondent shall also provide, if requested, an authorization for the Board to obtain a Criminal Offender Record Information (CORI) Report of the Respondent conducted by the Massachusetts Criminal History Systems Board and a sworn written statement that there are no pending actions or obligations, criminal or administrative, against the Respondent before any court or administrative body in any other jurisdiction.

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status and discipline history, and verifying that his nursing license is, or is eligible to be, in good standing and free of any restrictions or conditions.

3. Respondent shall provide documentation of his successful completion of all continuing education equivalent to the continuing education required by Board regulations for the two (2) license renewal cycles immediately preceding any request for suspension termination;

4. if employed during the year immediately preceding Respondent's petition for relicensure, have each employer from said year submit on official letterhead an evaluation reviewing Respondent's attendance, general reliability, and overall job performance;[79]

5. reports from Respondent's primary care provider and any specialist(s) whom Respondent may have consulted verifying that Respondent is medically able to resume the safe and competent practice of nursing, which meets the requirements set forth in Attachment B 1.

The Board's approval of Respondent's suspension termination shall be conditioned upon, and immediately followed by, probation of Respondent's nursing license for a period of time, as well as other restrictions and requirements that the Board may then determine are reasonably necessary in the best interests of the public health, safety, and welfare.

The Board may choose to relicense Respondent if the Board determines that relicensure is in the best interests of the public at large.

The Board voted to adopt the within Final Decision at its meeting held on December 8, 2010, by the following vote: **In favor:** S. Kelly, RN/NP, J. Killion, LPN, P. Remijan, RN, K. Harwood-Green, RN, E. Richard Rothmund, C. Simonian, RPh., C. Weekes-Cabey, RN, K. Gehly, RN, C. Lundeen, RN **Opposed:** None **Abstained:** None **Absent:** J. Faye Dubose, LPN, M. J. Roy, RN, R. Smith, LPN, MM

The Board voted to adopt the within Final Order at its meeting held on December 8, 2010, by the following vote: **In favor:** S. Kelly, RN/NP, J. Killion, LPN, P. Remijan, RN, K. Harwood-Green, RN, E. Richard Rothmund, C. Simonian, RPh., C. Weekes-Cabey, RN, K. Gehly, RN, C. Lundeen, RN **Opposed:** None **Abstained:** None **Absent:** J. Faye Dubose, LPN, M. J. Roy, RN, R. Smith, LPN, MM

EFFECTIVE DATE OF ORDER

This Final Decision and Order becomes effective upon the tenth (10th) day from the date it is issued (see "Date Issued" below).

[79] If Respondent wasn't employed at all during this period, submit an affidavit so attesting.

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RIGHT TO APPEAL

Respondent is hereby notified of the right to appeal this Final Decision and Order to the Supreme Judicial Court within thirty (30) days of receipt of notice of this Final Decision pursuant to M.G.L. c. 112, § 64.

Board of Registration in Nursing

Date Issued: December 13, 2010

Rula Harb, MSN, RN
Executive Director

Notified:
VIA FIRST CLASS AND CERTIFIED MAIL RETURN
RECEIPT REQUESTED NO.7010 0290 0001 0886 8233

Michael J. McAndrews
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BY HAND
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Department of Public Health
Division of Health Professions Licensure
239 Causeway Street, Suite 200
Boston, MA 02114

Vivian Bendix, Hearings Counsel

ATTACHMENT B 1

Minimum requirements for medical evaluations to be submitted to the Board

Medical evaluation

A medical evaluation of the Licensee conducted by a licensed, board certified physician written on the physician's letterhead, sent directly to the Board by the physician and completed within thirty (30) days before submission of the petition for reinstatement or other submission to the Board. The evaluation shall state that the physician has reviewed this document and any Board Consent Agreement, Order, and/or other relevant documents, and that he or she has reviewed the specific details of the Licensee's underlying conduct alleged or otherwise described.

The evaluation shall provide a detailed, clinically based assessment of the Licensee and shall be completed in accordance with all accepted standards for such an evaluation. The purpose of the evaluation is to provide the Board with the physician's analysis of the following materials and his or her opinion as to whether the Licensee is able to practice nursing in a safe and competent manner. To be most useful to the Board, the evaluation should include, but not be limited to, the following:

a. Record Review. A review of the Licensee's written or electronic medical and mental health records (for at least the preceding two years);

b. Conversation(s) with Provider(s). Follow up conversations with any currently or recently treating primary care physicians or advanced practice nurses and any mental health providers;

c. Review of Prescriptions. A list of all of the Licensee's prescribed medications with the medical necessity for each prescription; if there are or may be other prescribers than the evaluating physician then the evaluation should include a review of all of the Licensee's pharmacy records for the preceding two years;

d. In-Person Interview(s). Medical (and mental health if pertinent) history obtained by the physician through in-person interviews with the Licensee, which are as extensive as needed for the physician to reach a clinical judgment;

e. Detailed Statement of History. A detailed statement of the Licensee's medical (and mental health if pertinent) history including diagnoses, treatments and prognoses;

f. Detailed Description(s) of Current Conditions. Detailed descriptions of the Licensee's existing medical conditions with the corresponding status, treatments and prognosis including, but not limited to, each condition, if any, which gave rise to the conduct which is the subject of the Board's interest;

g. Any Existing Limitations. A detailed description of any and all corresponding existing or continuing limitations of any kind;

h. Ongoing Treatment Plan. Recommendations for the Licensee's on-going treatment and specific treatment plan, if any;

i. Evaluating Physician's Opinion as to Safety and Competence. The physician's opinion as to whether the Licensee is presently able to practice nursing in a safe and competent manner (in light of all of the above); and

j. Physician's C.V. A copy of the physician's curriculum vitae should be attached.

ATTACHMENT B 2

Minimum requirements for mental health evaluations to be submitted to the Board

Mental Health evaluation

A comprehensive mental health evaluation of the Licensee conducted by a licensed clinical psychologist (Ph.D or Psy.D or Ed.D) or a licensed, board certified psychiatrist written on said provider's letterhead, sent directly to the Board by the provider and completed within thirty (30) days before submission of the petition for reinstatement or other submission to the Board. The evaluation shall state that the provider has reviewed this document and any Board Consent Agreement, Order, and/or other relevant documents, and that he or she has reviewed the specific details of the Licensee's underlying conduct alleged or otherwise described.

The evaluation shall provide a detailed, clinically based assessment of the Licensee and shall be completed in accordance with all accepted standards for such an evaluation. The purpose of the evaluation is to provide the Board with the provider's analysis of the following materials and his or her opinion as to whether the Licensee is able to practice nursing in a safe and competent manner. To be most useful to the Board, the evaluation should include, but not be limited to, the following:

a. Record Review. A review of the Licensee's written or electronic mental health records (for at least the preceding two years) (and medical records from the same time frame if pertinent);

b. Conversation(s) with Provider(s). Follow up conversations with any currently or recently treating mental health providers (and primary care physicians or advanced practice nurses as relevant);

c. Review of Prescriptions. A list of all of the Licensee's prescribed medications with the medical necessity for each prescription; if there are or may be other prescribers than the evaluating provider; then the evaluation should include a review of all of the Licensee's pharmacy records for the preceding two years;

d. In-Person Interview(s). Mental health (and medical if pertinent) history obtained by the provider through in-person interviews with the Licensee, which are as extensive as needed for the provider to reach a clinical judgment;

e. Detailed Statement of History. A detailed statement of the Licensee's mental health (and medical if pertinent) history including diagnoses, treatments and prognoses;

f. Detailed Description(s) of Current Conditions. Detailed descriptions of the Licensee's existing mental health conditions with the corresponding status,

treatments and prognosis including, but not limited to, each condition, if any, which gave rise to the conduct which is the subject of the Board's interest;

g. Specific Assessments. Assessments of the Licensee in each of the following areas:

i. Cognition status - orientation to time, place and person; ability to recognize and organize responsibilities accurately and to make accurate, appropriate decisions; critical thinking ability sufficient for appropriate clinical judgment; and ability to collect and analyze data to problem solve efficiently and accurately, and to identify cause and effect relationships accurately.

ii. Affective status- interpersonal skills sufficient to interact appropriately and honestly with individuals, families and groups; and ability to recognize and conform to lawful standards of social conduct.

iii. Ability to recognize the limits of professional boundaries and the risk that the Licensee will violate professional boundaries with patients.

iv. Ability to control her/his impulses; and the likelihood that she/he will repeat any of the conduct that gave rise to the Board's review of his/her safety and competency in nursing practice.

h. Summary of Progress and/or Limitations. A summary of the progress Licensee has made in treatment and detailed description of any and all corresponding existing or continuing limitations of any kind;

i. Ongoing Treatment Plan. Recommendations for the Licensee's on-going treatment and specific treatment plan, if any;

j. Evaluating Physician's Opinion as to Safety and Competence. The provider's opinion as to whether the Licensee is presently able to practice nursing in a safe and competent manner (in light of all of the above); and

k. Provider's C.V. A copy of the provider's curriculum vitae should be attached.

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